



US healthcare and the Affordable Care Act: why the US does not have a UK-style National Health Service

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Abstract:

In 2010, the United States Congress was entangled in a debate over healthcare reform that divided the nation. Some supporters of healthcare reform questioned why the US failed to emulate the United Kingdom with a National Health Service (NHS) characterized by universal coverage. This paper explores the evolution of healthcare systems in the US and the UK in the first half of the twentieth century to demonstrate the importance of historical institutionalism and path dependency in shaping their present systems. Drawing upon historical analyses of the US and UK systems, this paper then seeks to analyse the passage of the 2010 Affordable Care Act (ACA) under the Obama administration. While the overall ramifications of the ACA remain uncertain, its passage marks a critical moment in the development of the US healthcare system, diverging from a history of failed reforms.

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Introduction

In 2010, the United States Congress was entangled in a debate over healthcare reform that divided the nation. Headlines about ‘death panels’ and ‘socialist medicine’ were broadcast by opponents, as conservative campaigners warned against the danger of a United Kingdom-style National Health Service (NHS), while some supporters of healthcare reform wished to emulate the UK’s system of universal coverage. The striking differences between the private insurance-based health system of the US and the state-run system in the UK stand out within the field of welfare state research. Both countries are classified as liberal welfare states within Esping-Andersen’s typology, and they exhibit many similarities, including a proclivity toward a weak welfare state and means-tested benefits, yet they diverge in their approach to healthcare. This paper will explore the evolution of healthcare systems in the US and the UK in the first half of the twentieth century to demonstrate the importance of historical institutionalism and path dependency in shaping their present systems. Drawing upon historical analyses of the US and UK systems (Steinmo and Watts, 1995; Hacker, 1998; Thomasson, 2002), this paper then seeks to analyse the passage of the 2010 Affordable Care Act (ACA) under the Obama administration. While the overall ramifications of the ACA remain uncertain, its passage marks a critical moment in the development of the US healthcare system, diverging from a history of failed reforms.

Methodology: Path Dependency and Historical Institutionalism

Events do not take place in a vacuum divorced from history—past policy decisions, political institutions, and actors all play a critical role in shaping contemporary debates. The definition of path dependency varies in the literature and is sometimes reduced to the generalization that the past shapes the future. This paper utilizes a narrower understanding of the theory advanced by Paul Pierson that “steps in a particular direction induce further movement in the same direction”, reinforced by a process of increasing returns whereby the relative benefits of the current path grow exponentially over time (2000, p. 252). Embedded in this theory is a desire to understand the causal nature of social mechanisms by highlighting ‘switch points’ (critical moments that offer the potential for deviation) and ‘critical junctures’ (decisions that constrain future development and reinforce a given path) (ibid.). Path dependency helps account for the continuation of suboptimal policies which economic theory would expect to be corrected over time (Haydu 1998). Thus the theory is particularly relevant to the US health system, which is both less inclusive and more expensive than the UK’s NHS.

Path dependency is used by historical institutionalists to highlight key moments in institutional formation, as well as to explain the constraints that the past places around their evolution. Historical institutionalism focuses on the role of institutions in shaping the actions of political actors, as well as the interactions between institutions (Thelen, 1999). This paper



will focus on formal political institutions—the bodies of government and rules of law—that shaped the formation of the health systems in the US and UK.

Path dependency and historical institutionalism provide the opportunity to analyse cases in depth and to advance causal explanations; however, they also contain limitations. Path dependency's emphasis on 'switch points' and 'critical junctures' can provide an overly narrow understanding of how the past shapes the present. Similarly, focusing on historical institutions without taking broader environmental changes into account could fail to reveal the altered role of political institutions in their new context (Pierson, 2004). Recognizing these limitations, this paper does not seek to discount the role of politicians, lobbyists, and other actors in shaping reform; rather, it aims to provide a broader understanding of the historical context in which these actors operate and the symbiotic relationship between institutions and policies that evolved over time.

UK: Establishing National Health Insurance (1800s-1930s)

The origins of the National Health Service (NHS) in Britain can be traced to the 1911 National Insurance Act, which established insurance for industrial workers (Sokolovsky, 1998). Of key importance, the Act created a compulsory and contributory social insurance program that provided access to personal health services and compensated workers for lost wages due to illness (Hacker, 1998). Prior to the Act's passage, industrialization and a growing population during the nineteenth century sparked concerns over living conditions and the health of the lower class, particularly in regard to their ability to provide labour and serve in the military. Voluntary organizations, funded by donations from the middle and upper class, seemed well-placed to provide hospital care, yet access was limited and hospitals were concentrated in affluent areas of society. Similarly, many Friendly Societies—voluntary associations for the working-class—offered sickness benefits, yet membership was primarily confined to male, high-skilled workers (Carrier and Kendall, 1998). This gap in coverage left the nation susceptible to public health crises and precipitated government intervention through the Poor Acts, which helped establish the state's legitimacy in the healthcare field (Allsop, 1995).

Emerging from the nineteenth century, voluntary organisations, insurers, and the government all had an invested role in healthcare, which Chancellor David Lloyd George and his Liberal Party had to address when pursuing a national insurance scheme. Although the Poor Laws had established the government's legitimacy in intervening in healthcare in the eyes of the medical profession and society, the voluntary sector and Friendly Societies represented a potential barrier to the passage of legislation. The government's ability to increase its role in healthcare was aided by divisions between the medical profession and voluntary sector that emerged in nineteenth century (Carrier and Kendall, 1998). Lloyd George capitalized on the British Medical Association's dissatisfaction with voluntary and Friendly societies, while also appeasing Friendly Societies by giving them administrative control of the government scheme (Hacker, 1998). Although these concessions complicated the Act and hindered its scope, they appeased the concerns of its challengers while also assuring that healthcare reform would remain on the political agenda for subsequent decades.

While political prowess played an important role in establishing the Act, its passage was aided by a unitary parliamentary system with fewer hurdles than the complex system of checks and balances in the US. Once in power, a majority party could more quickly advance



its agenda. However, the Liberal Party appreciated a small margin in Parliament at the time of the Act's negotiation, which necessitated an alliance with the Labour Party to ensure its passage (Sokolovsky, 1998). This move by the Liberal Party was prescient, as Labour would later play a critical role in the creation of the NHS. Outside of parliament, the UK's well-established administrative system both endorsed the passage of welfare measures and ensured that the government was in a position to handle their implementation. In contrast to the federal system of the US, the UK's strong central authority also concentrated power and led to healthcare oversight at the national level (Hacker, 1997). Thus the UK's political structure and professional bureaucracy enabled the government to take an active role in healthcare.

UK: Creation of the National Health Service (1940s-1950s)

The creation of the NHS in 1946 was both a continuation of the process set in motion through the 1911 National Insurance Act and the result of public support for a strong welfare state in the aftermath of World War II. The insurance system created by the 1911 Act, though a major development, was plagued by limitations. It covered less than fifty percent of the population and led to uneven coverage based on an unequal distribution of health risks among insurance pools (Hacker, 1998). The failings of health insurance demonstrated the need for an alternative form of coverage, and over the next three decades, a number of ideas for reform were proposed.

WWII served as a pivotal event in the expansion of the UK's welfare state, though the reforms implemented were a product of debates that had evolved over the first half of the century. Deficiencies within the social insurance system and the need to prepare for post-war reconstruction, prompted the creation of a committee, headed by William Beveridge, to examine the current system and make recommendations for its reform. The resulting report on Social Insurance and Allied Services, commonly known as the Beveridge Report, decried the 'piece-meal' nature of the existing system and recommended a shift to a single national insurance scheme that would provide universal coverage (Carrier and Kendall, 1998). Of key importance, the report proposed that 'medical treatment covering all requirements will be provided for all citizens by a national health service organised under the health department' (Beveridge Report, 1942, p.10). State-administered universal health coverage was a crucial aspect of the report, not only to provide for the health of the nation, but also to enable the sustainability of the social insurance system by maintaining a healthy workforce and decreasing losses due to disability.

Although the Beveridge Report faced opposition, particularly from the Approved Societies who risked losing their administrative authority under a NHS, the report received widespread public support. A Gallup Poll conducted in 1942 found that 9 out of 10 people supported the report's aims. Thus the goal of creating a comprehensive and universal health service after the war became embedded in the political agenda (Carrier and Kendall, 1998). However, efforts to move toward a universal system threatened to disrupt the delicate compromise between the state, insurers, and medical profession that enabled the passage of NHI in 1911. The British Medical Association, while originally supportive of reform, was wary of losing independence. In addition, politicians faced the challenge of financing the NHS in a time when the nation's infrastructure was in need of major repair (Morgan, 1948). Despite these challenges, a decisive victory by the Labour Party in 1945 placed them in a position to push through the passage of the NHS Act in 1946. As in 1911, concessions were made to the medical profession, such as enabling medical specialists to practice privately in hospitals;



however, these concessions were minor in the context of a bill that nationalized hospitals, extended coverage to the entire population, and made services free at the time of service (Hacker, 1998).

Establishing the NHS served as a lock-in moment in history. Although the NHS was in perpetual financial crises in the decades following its creation, it quickly became embedded in society. As Eckstein noted, “The service has scored considerable popular success—to the point indeed, where, ten years after its inception, it seems to be accepted as an altogether natural feature of the British landscape” (1958, p.2). History demonstrates that, once introduced, social services prove difficult to revoke.¹

US: Failure of Progressive reforms and the rise of the American Medical Association (1900-1930)

The private health insurance system which now dominates US healthcare was not a foregone conclusion. At the beginning of the twentieth century, few Americans possessed health coverage and national provision of social insurance was high on the agenda of social reformers and the Progressive Party. Progressives in the US tracked the passage of the UK’s 1911 National Insurance Act and were keen to pass similar legislation (Hacker, 1998). In the 1912 presidential election, the Progressive Party campaigned for a system of social insurance that would provide for Americans in times of sickness, irregular employment, and old age (Steinmo and Watts, 1995). However, the Progressive candidate, Theodore Roosevelt, lost the election to Democratic candidate, Woodrow Wilson. Although Roosevelt garnered 27.4 percent of the popular vote, the winner-takes-all design of the US political system supports two-party power and relegates third parties to the outskirts of politics. In contrast, the passage of the 1911 National Insurance Act in the UK was helped by cooperation between the Liberals and Labour. Although the Labour Party had only earned 6.4 percent of the vote, they held 42 parliamentary seats making them a necessary ally for the Liberal Party (Hacker, 1998).

The inability to shape national politics led the Progressive Party to seek social reforms at the state level. This approach further undermined the possibility of a national health insurance system (NHI). The additional challenge of this approach was that reformers had to deal with unwieldy state bureaucracies, as well as wide regional variations in ideology and economic development. In addition, government managed hospitals and public health efforts were rare, creating limited precedent for intervention (Hacker, 1998). Thus the push for social reform in the US was slow out of necessity due to the structure of the country’s political institutions and a lack of established legitimacy in the healthcare field. In contrast, the centralization of authority in the UK and its advanced professional bureaucracy were boons to the passage of social reforms that built upon the nineteenth century Poor Acts.

By the end of the 1920s, changes in surgical techniques and improvements in the field of bacteriology provided people with more confidence in the medical profession (Thomasson, 2002). The increased demand for medical services bolstered the lobbying power of doctors via the American Medical Association (AMA), forming a powerful voice against any congressional effort to impose compulsory contribution-based insurance (Hacker, 1998). The

¹ Despite the NHS’ popularity, the emergence of neoliberalism has led to several efforts to reform the NHS and introduce private competition. For an analysis of reforms introduced in the 1980s-90s, see Allsop, 1995.



rise of the medical profession due to technological advancement demonstrates the importance of sequencing in path dependency. In the US, the AMA established itself as a critical voice of opposition against state involvement in healthcare before the government could establish a foothold in the field. In contrast, the UK's 1911 National Insurance Act created a dependency between doctors and the state before the advancement of medical technology (ibid). US politics and institutions hindered the passage of health insurance legislation at a time when the medical profession was more open to intervention and this delay made subsequent efforts more likely to fail.

US: Establishing Private Health Insurance, Medicare and Medicaid (1930s-1960s)

As in the UK, the Great Depression and WWII served as a critical juncture in the development of the welfare state. During the 1930s, the US government, under the leadership of President Franklin Roosevelt, passed wide-sweeping reforms, including the Social Security Act. The notable exception was healthcare reform. Although compulsory health insurance was supported by a majority of Americans and ranked high on Roosevelt's agenda, internal party divisions and the lobbying power of the AMA prohibited the inclusion of health insurance in final legislation (Quadagno, 2005). A similar combination of factors led to President Harry Truman's failure to enact NHI between 1948 and 1950. Demonstrating its growing power, the AMA spent millions of dollars on an advertising campaign that capitalized on America's Cold War fears by linking NHI with socialism (Hacker, 1998). Within Congress, Truman's efforts were hindered by the committee system which grants significant power to senior members of Congress through their role as committee chairmen. When a bill is in committee, institutional rules enable the committee to effectively kill the legislation by failing to introduce it to Congress for debate. In the case of NHI, institutional rules played a larger role in shaping policy than the demands of the President and the public, as the legislation failed to make it out of committee in both the House and Senate (Steinmo and Watts, 1995).

The failure to pass NHI despite growing public desire for coverage created an opening for the private insurance industry. During the war, some employers began offering health benefits as a means of attracting employees (Thomasson, 2002). This linkage between employment and health coverage was enhanced by labour union efforts to expand employment benefits, leading to a rapid increase in the number of Americans covered by private health insurance (Hacker, 1998). The US tax system reinforced this trajectory: employer-provided contributions to employee health insurance plans were exempt from payroll taxes, creating an incentive for employers to offer health plans (Thomasson, 2002). At this stage, the employment-based system of health coverage in the US exhibited parallels to the UK's 1911 National Insurance Act. While important distinctions exist due to the role of the state in the latter, both led to gaps in coverage that disadvantaged those outside employment. Yet while this limitation served as an impetus for the creation of the NHS in the UK, in the US it led to a strategy that further undermined the potential for comprehensive NHI.

By the 1960s, the failures of NHI legislation prompted the emergence of a new, incremental strategy toward reform. This strategy aimed to provide health coverage for two of the most vulnerable groups in society—the elderly and the poor. In 1965, President Lyndon Johnson helped push through legislation that established Medicare as an NHI program for the elderly, while expanding coverage for the poor through the Medicaid program. The rationale behind this move was that establishing coverage for groups with limited access to the private



insurance market would open the door to further expansion of the program (Hacker, 1998). This incremental approach mimics the logic of Lloyd George who recognized the limitations of the 1911 National Insurance Act and believed this would necessitate later reform. Yet the two strategies had markedly different results, in part due to the populations they targeted. The 1911 Act provided coverage for workers—the lack of coverage for vulnerable groups offered pressure for expansion. In contrast, the creation of Medicare and Medicaid provided for society’s most vulnerable, leaving private insurance to cover working members of the population. The state was left to cover high risk groups, enabling private insurers to offer more competitive prices due to their coverage of lower risk populations (Thomasson, 2002). By the 1960s, the US and UK health systems were developing along distinct trajectories shaped by the timing of reform efforts and distinctions between their political systems.

US: Failed Reforms and the Passage of the Affordable Care Act (1970s-2012)

Following the creation of Medicare and Medicaid in the US, the passage of comprehensive NHI remained an elusive goal for subsequent generations of political leaders. By the 1970s, the rising costs of Medicare and Medicaid within a ‘fee-for-service’ medical system were threatening to undermine the government’s ability to pay for other social services. This financial untenability led economist Alice Rivlin to write that the enactment of NHI “now seems virtually certain: (quoted in Steinmo and Watts, 1995, p.350). Yet despite this financial imperative, the endorsement of several influential congressmen, and public support, NHI legislation was defeated during the Nixon, Ford, Carter, and Clinton administrations.

Although a myriad of factors combined to undermine reform, Steinmo and Watts (1995) contend that the structure of the American political system served as the primary reason for defeat. Each effort to introduce NHI legislation was hindered by Congressional fragmentation and an inability to bring political factions in line with the majority party’s agenda. In addition, efforts by senators such as Edward Kennedy to pursue incremental expansion to healthcare were undermined by comprehensive bills introduced by other senators (ibid). Beyond the complexities of the political system, the timing of the efforts also served as a barrier to reform. By the 1970s, ninety percent of the public were covered by private insurance—the system was entrenched in society and had the financial resources to lobby against government intervention (Hacker 1998).

Path dependency suggests that subsequent steps along a path reinforce that trajectory and discourage departure. From this perspective, each failure to implement NHI decreased the likelihood of future success. In light of this trend, the passage of the Affordable Care Act in 2010 was a pivotal moment in the history of US healthcare. A comprehensive overview of the ACA goes beyond the scope of this paper; however, the following questions are particularly pertinent to the discussion of path dependency and historical institutionalism: Why was reform possible in 2010 and not in other years? What aspects of the bill reinforce the existing health system and what aspects alter its landscape?

Barack Obama made health reform one of his primary campaign issues in 2008, and his supporters elected him to office with a hope of far-reaching reform. Yet from the time Obama announced his plan to begin working with Congress on healthcare reform in February 2009, the factors that had thwarted past reform efforts—party division, the committee system, the complex process of passing legislation, and the lobbying power of the medical and insurance industries—all stood in the way of reform (Gottschalk, 2011). However, while institutions



and past policies constrain reform and tend to uphold the status quo, outside shocks such as economic disaster can provide the opening for change.

The 2008 economic recession played a decisive role in shaping the debate about the ACA. One of the fundamental aims of health reform was to extend coverage to the estimated 30 million Americans without coverage (Obama, 2009). The recession and resulting unemployment further underscored this need—in a time of economic turmoil, the connection between employment and health coverage meant that even the employed felt less secure about their future coverage. Simultaneously, rising healthcare costs placed a burden on businesses, prompting some companies to discontinue or reduce healthcare plans for their employees (*ibid.*). The recession also placed further strain on the government to pay for existing social services, including Medicare, due to a shrinking tax base and aging population. Although rising healthcare costs had driven reform efforts since the 1970s, the 2008 recession placed additional pressure on the government to succeed by fuelling public criticism of the status quo.

Although the economic crisis opened the door to reform, institutions and past policies shaped the boundaries of what could be achieved. The ACA focused on expanding insurance coverage, not on reforming the provision of care—the creation of a service akin to the NHS was never on the table. The possibility of introducing a single-payer system in which necessary expenditures would be paid for out of a federal fund was introduced in the House; however, the bill never made it out of committee (The Library of Congress, 2013). While the private insurance industry launched an attack to oppose a public option, the industry was willing to accept stricter regulations, including an end to denying coverage based on pre-existing conditions, if coupled with a mandate to bring young people into the insurance pool (Quadagno, p. 2011). The version of the ACA that ultimately passed reflects the complexities of the US political system and the need to compromise with interest groups invested in the healthcare industry. Crucial to the implementation of reform will be the establishment of state-level insurance-exchanges in 2014 to monitor the purchase and sale of health insurance—a role in line with the strong federalist tradition of upholding states' rights. This suggests that there will be wide variation in the way that reform is implemented in different states. At one extreme this may lead to the decision to opt-out of aspects of the bill (a right that is codified in the Act), while it also will enable the states to serve as laboratories to discover best practices (Jost, 2010).

Conclusion

Historical institutionalism and path dependency provide key insights into the US health system and reform efforts. While some in the US decried the ACA for not going far enough to provide coverage akin to the UK's NHS, an examination of the development of both systems reveals the complex combination of factors that established their separate trajectories and reinforced them over time. Yet the passage of the ACA also demonstrates that path dependency and historical institutionalism do not exclude the potential for change. Policies and institutions are influenced by contemporary events and major shocks such as economic recession can enable a diversion from the existing path. The passage of the ACA after a history of failed reforms marks a critical juncture in the development of US healthcare. While the ACA remains controversial, the Supreme Court decision in June 2012 to uphold most aspects of the legislation suggests that it will have lasting effects on the healthcare system.



However, the specific outcomes of the ACA will only become evident as provisions of the Act are introduced over the remainder of the decade.



References

- Allsop, J. (1995) *Health Policy and the NHS Towards 2000*, 2nd ed, London: Longman Group Limited.
- Amenta, E. (2003) 'What We Know about the Development of Social Policy. Comparative and Historical Research in Comparative and Historical Perspective' in J. Mahoney and D. Rueschemeyer (eds.) *Comparative Historical Analysis in the Social Sciences*. Cambridge: Cambridge University Press.
- Beveridge, W. (1942) *Social Insurance and Allied Services*, London, HMSO, Cmd. 6404.
- Carrier, J. and Kendall, I. (1998) *Health and the National Health Service*, London: The Athlone Press.
- Chasse, J.D. (1994) 'The American Association for Labor Legislation and the Institutionalist Tradition in National Health Insurance', *Journal of Economic Issues*, 28(4), pp. 1063-1090.
- Eckstein, H. (1958) *The English Health Service: Its Origins, Structure and Achievements*, Cambridge: Harvard University Press.
- Gottschalk, M. (2011) 'They're Back: The Public Plan, the Reincarnation of Harry and Louise, and the Limits of Obamacare', *Journal of Health Politics, Policy, and Law*, 36(3), pp. 393-400.
- Hacker, J. (1998) 'The Historical Logic of National Health Insurance: Structure and Sequence in the Development of British, Canadian, and U.S. Medical Policy', *Studies in American Political Development*, 12, pp. 57-130.
- Ham, C. (1981) *Policy-Making in the National Health Service*, London: The Macmillan Press Ltd.
- Haydu, J. (1998) 'Making Use of the Past: Time Periods as Cases to Compare and as Sequences of Problem Solving', *American Journal of Sociology*, 104(2), pp. 339-371.
- Heins, E. 'Historical Comparisons', Lecture: University of Edinburgh, 13 March, 2013.
- Hodgkinson, R. (1967) *The Origins of the National Health Service: The Medical Services of the New Poor Law 1834-1871*, London: The Wellcome Historical Medical Library.
- Jost, T.S. (2010) 'Health Insurance Exchanges and the Affordable Care Act: Key Issues' Common Wealth Fund, Report No. 1444.
- Mahoney, J. and Rueschemeyer, D. (eds) (2004) *Comparative Historical Analysis in the Social Sciences*, Cambridge: Cambridge University Press.



- Mahoney, J. and Villegas, Celso M. (2007) 'Historical Enquiry and Comparative Politics', ch. 3, from Charles Boix and Susan C. Stokes (eds.), *The Oxford handbook of Comparative Politics*, Oxford: Oxford University Press.
- Morgan, K.O. (1984) *Labour in Power 1945-1951*, Oxford: Clarendon Press.
- Obama, B. 'Health Care Speech to Congress', Washington, DC, 9 September, 2009.
Transcript available at: <<http://www.nytimes.com/2009/09/10/us/politics/10obama.text.html?pagewanted=all>>.
- Pierson, P. (2000) 'Increasing Returns, Path Dependence, and the Study of Politics', *American Political Science Review*, 94(2), pp. 251-267.
- Pierson, P. (2003) 'Big, Slow-Moving, and...Invisible: Macrosocial Processes in the Study of Comparative Politics' in J. Mahoney and D. Rueschemeyer (eds.) *Comparative Historical Analysis in the Social Sciences*. Cambridge: Cambridge University Press.
- Pierson, P. (2004) *Politics in Time: History, Institutions, and Social Analysis*, Princeton: Princeton University Press.
- Quadagno, J. (2005) *One Nation, Uninsured: Why the U.S. Has No National Health Insurance*, Oxford: Oxford University Press.
- Quadagno, J. (2011) 'Interest-Group Influence on the Patient Protection and Affordability Act of 2010: Winners and Losers in the Health Care Reform Debate', *Journal of Health Politics, Policy and Law*, 36 (3), pp. 449-453.
- Rivett, G. (1998) *From Cradle to Grave: Fifty Years of the NHS*, London: King's Fund Publishing.
- Skocpol, T. and Somers, M. (1980) 'The Uses of Comparative History in Macrosocial Inquiry', *Comparative Studies in Society and History*, 22, pp. 174-197.
- Sokolovsky, J. (1998) 'The Making of National Health Insurance in Britain and Canada: Institutional Analysis and its Limits', *Journal of Historical Sociology*, 11(2), pp. 247-280.
- Steinmo, S. and Watts, J. (1995) 'It's the Institutions, Stupid! Why Comprehensive National Health Insurance Always Fails in America', *Journal of Health Politics, Policy and Law*, 20(2), pp. 329-368.
- Thelen, K. (1999) 'Historical Institutionalism in Comparative Politics', *Annual Review of Political Science*, 2, pp. 369-404.
- The Library of Congress (2013) *Bill Summary and Status H.R.676*, Available at: <<http://thomas.loc.gov/cgi-bin/bdquery/z?d113:h.r.676>>.
- Thomasson, M.A. (2002) 'From Sickness to Health: The Twentieth-Century Development of U.S. Health Insurance', *Explorations in Economic History*, 39, pp. 233-253.



Tilly, C. (1984) *Big Structures, Large Processes, Huge Comparisons*, New York: Russell Sage Foundation.

