Colleen M. Grogan. 2023. *Grow and Hide: The History of America's Health Care State*. New York: Oxford University Press, 2023. 448 pages. 26 illustrations. Hardcover.

Everybody who teaches health politics and policy has a list of their favorite anomalies: surprising facts about the policy landscape in which health policies contradict students' expectations The United States, as is to be expected, is particularly rich in anomalies (e.g.: you think the United States doesn't have an NHS system? Let me introduce you to the VA!). Everybody who has to explain the system will have their own favorite ones to discuss in class.

Colleen Grogan's new book, *Grow and Hide*, does what good science should do. The book turns the anomalies not into a teaching trick or challenge but data for a better theory. The book reframes the debate about American health policy around a basic question: why is it apparently a market while awash in public expenditure? How is it that the US can be coded, by scholars and voters alike, as a market when its *public* expenditure on health care as a share of GDP is higher than total health care expenditure for most OECD members?

The answer, she explains across a history of almost a century, is a longstanding politics in which interest groups and politicians of all sorts colluded to expand public expenditure and support for their interests (grow) while consistently using superficial and distorting market mechanisms to preserve the myth of a market-based health care system (hide). Part of the hiding strategy is to selectively highlight and fight about only a few public programs and regulatory actions, namely the ones that benefit the poor, but there are many other mechanisms that hide public subsidy. To make her argument, she synthesizes a vast array of secondary literature and delves into some of the more obscure corners of scholarly research and government documents, making her book both an original contribution and a synthetic review of a whole field's work.

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One of the greatest contributions of the book is that it puts capital squarely in the center of the picture. That means capital both in the sense of money and the people who own it, and capital in the sense of capital expenditure, the big and literally hard expenditure category for items like buildings and big technology investments.

Health system analyses and profiles everywhere have a tendency to focus on running costs- the ways that doctors are paid or procedures reimbursed. Endless volumes debate capitation and fee for service and value based purchasing and other ways to incentivize or disincentivize a given colonoscopy or knee surgery. But there is far less attention to the huge sums of money that flow into capital expenditure and the enormous impact that capital expenditure and the need for capital have on the way health systems operate. This is odd, since the reality of infrastructure and the need for capital to build or buy expensive technology are enormously powerful influences on the development and delivery of health care anywhere. It is particularly odd in the case of the United States, where there is a lot of private financial capital already in the health care system, and where private equity is increasingly finding new and parasitic ways to exploit the system while likely developing exit strategies that will promote local provider concentration (Fuse Brown & Hall, 2024; Olson, 2022; Alexander, Geronimo, Moriah, & Joseph, 2023).

Looking at capital does much to reframe the distinctiveness of the United States health care system compared to others. In most other rich countries, regardless of divisions such as Bismarck or Beveridge, the capital budget that structures health care is controlled by governments and often comes directly from public budgets. This means that governments are powerful, if hidden behind a screen of talk about self-administration or markets, and also means that market mechanisms are ultimately not that powerful (Greer, Klasa, & Van Ginneken, 2020).

In the United States, capital expenditure is determined by the owners of capital. As Grogan shows, state and federal governments built a "hidden financial system" that allows health care providers to raise capital under very advantageous terms in private markets. This system allows and hides the fabulous growth of US health care infrastructure while also systematically removing the tools that would permit governments to direct it for any purpose, or even make it act more like a competitive market (a lot of those primary care ventures' exit strategies likely involve selling to local provider systems, furthering market concentration). Blindness to the importance of capital expenditure is a feature of many systems. But in the United States such blindness enables a financial system that is historically poor value for money and, once exploited by private equity, can be an outright danger to what equity and efficiency are to be found in the sector.

The deliberate ways in which an entire financial system was hidden reflects a theme of the whole book: the ways statistics, more or less intentionally, misrepresent the US health care and public health systems by downplaying public expenditure, and its role in making the ostensibly private or nonprofit US health care sector viable. Historians have noted the strategies and political actions which brought this situation into existence (Klein, 2003; Chapin, 2015) but those insights have only imperfectly influenced political science and comparative health systems research.

In part, that failure to appreciate the politics of data is because many political scientists, like economists, like data sets somebody else produced. They don't always look too closely at what produced them or why. The politics of statistics should be of more interest to political scientists, since the design and manipulation of data is a powerful way to create or obscure political problems and is therefore of intense interest to politicians and interest groups (Lynch,

2023; Greer, 2022). Judging by the number of political scientists still using COVID-19 case and fatality data as if they were unproblematic reflections of reality, even a massive pandemic and years of fascination with epidemiological statistics failed to interest us as a discipline in the politics of data. If COVID-19 failed to convince political scientists that data is political, perhaps Grogan's work can.

One field that is enormously resistant to characterization, in the US or in comparative perspective, is public health. Grogan's book explains why. One of the most salient facts about public health as an activity, field of inquiry, or something else remains how variable it is across time and place (Fierlbeck, 2024). Grogan shows, better than any previous account, how it changes and evolves in the United States over time.

Part of the reason for the basic instability of the concept of "public health" is the particular relationship between health policy and state building in the United States. For understandable reasons that Grogan documents, public health reformers in the nineteenth and most of the twentieth century were leery of local governments. Reformers, especially Progressives, were part of a larger story of class, race, ethnicity and religion in the United States at the turn of the twentieth century. They saw local governments as corrupt, clientelistic, and generally untrustworthy, views that mixed well founded skepticism about urban machines with a range of racist, religious, ethnic and other prejudices. The result was that public health leaders in the US often cobbled together a coalition of private foundations, nonprofits, and the most technocratic of state and federal agencies in an effort to circumvent or manipulate local polities.

This disconnection between reform, public health, and the core of local government empowered private interests in politics and delivery, particularly foundations, while disempowering democratically accountable local governments. For all the extensive literature on

the role of technocrats, foundations, private finance and nonprofit provision in American health policy history, or of the politics of clientelism and machines in American political development, there have been few accounts that so explicitly link the two issues and show the results. The insight might have comparative extension, since state formation, corruption, and local variations also occur in other rich democracies and shaped their politics (Shefter, 1993). Moreover, charities and technocrats who do not accept that imperfectly administered or imperfectly democratic governments should administer public health are a powerful force in global health today. They continue to replicate, on a global scale, the dynamics that led the Rockefeller doctors to distrust Tammany Hall. It is easy to moralize about this issue, but advocates of government and advocates of circumventing government will often have a point.

The reforming elites who tried to make public health with as little participation as possible from the public were socially and ideologically close to the medical reformist elites who focused on reforming not public health or health access but, rather, medicine. Grogan revives and puts more evidence behind Daniel Fox's focus on "hierarchical regionalism" as a unifying project of medical elites in the United States for much of the twentieth century (Fox, 1986). These elites were primarily focused on reforming doctors' behavior and centralizing medical resources in elite institutions, for reasons that will be familiar to those who follow contemporary debates about quality, volume, and practice variations (White, 2011). Reforming medicine is an almost inevitable preoccupation of academic medical elites. But medial reform works differently when it is an "aspirational agenda" in systems with universal health care, where tradeoffs are more visible and judged by democratically elected politicians (White, 2013). In the context of the United States, that reforming agenda is a very imperfect substitute for a health system. The result

has been policies that entrench and enrich academic medical centers while fragmenting health care, government, and potential movements for reform.

Growing and hiding also, as we have come to expect, involves not just obscuring flows of money but also obscuring the intent and functioning of regulation. In case after case in this book, we see a pattern visible elsewhere in American public policy, for example regulations on guns: powerful interests engage in the process so as to ensure that regulations will be ineffective and burdensome, which will then allow them to continue as before while pointing to the ineffective and burdensome nature of regulations in order to argue against more or better regulations (Lacombe, 2021). For those who do not wish to be regulated, burdensome and ineffective regulations are a short-term win and a long-term investment in skepticism about government.

Grogan's book synthesizes and might well replace many classic works of health politics known to readers of this journal, but as a product of that tradition it is somewhat at odds with a different approach, one which foregrounds racialized capitalism. Race in the book often appears as a necessary but not sufficient condition: in a United States where race and politics interacted in a given way at a given time, Grogan explains how health politics worked. But it would be an interesting extension to think through the ways that political elites of the Jim Crow South shaped what kinds of federal policy were possible. The story, as told by Grogan and many others, often reads as having largely northern, urban, protagonists: reformers, unions, doctors, and a few enterprising state governments. But how was that shaped by southern elites' combination of appetite for subsidy and absolute refusal of federal interventions that might undo Jim Crow (Sledge, 2017)?

This is not just a question at the global level of the role of racism, systemic, political, or otherwise, in US politics. It also works through some more subtle mechanisms that might cast

some of the book's thought in a different light. For example, it is not clear that we can understand the development of public health in the United States without linking it to essentially colonialist enterprises such as the assault on yellow fever in Cuba. Many of the leaders of US public health domestically had experience abroad and drew lessons from colonial and tropical medicine that influenced what they did in the United States. What lessons for the South came from Public Health Service officers' youthful experience eradicating mosquitos in occupied territories? What does it mean that CDC epidemiologist Alexander Langmuir, who gave surveillance its modern definition, spent a significant part of his career in the Pentagon working on bioweapons (Fearnley, 2010)?

The tendency to write a story of the North, its cities, and the federal government is common but is not unproblematic. *Grow and Hide* has a double problem that afflicts much historiography of health care in the United States and elsewhere. We might call it the New York City problem. New York City appears far too often in this book and in most others, for the same reasons that a few other cities show up rather too often (Milwaukee, Boston, Philadelphia, Pennsylvania) and some never seem to crop up (e.g. Detroit, Minneapolis, St. Louis, Cleveland, Pittsburgh, Washington, let alone southern or western cities). The double problem is that there is more modern scholarly output about New York City than about some other big cities; and that there are more contemporary primary sources because activists and officials based in New York City wrote a lot at the time. What would the history of US health policy look like if our understanding of local realities could rely less on self-promotion or self-critique from Manhattan, and more on accounts of contemporaneous health care and policy in Memphis, or San Francisco, or Philadelphia, Mississippi?

Grow and Hide, in short, combines a synthesis of a huge literature with new empirical research to rewrite the narrative of American health policy and shine a light into extremely interesting corners as different as private equity and county public health departments. It is a spectacular work, and discussions of the US health care sector and its eccentricities should not take place without reference to it.

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