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# NATIONAL HEALTH ACT OF 1945

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## REPORT

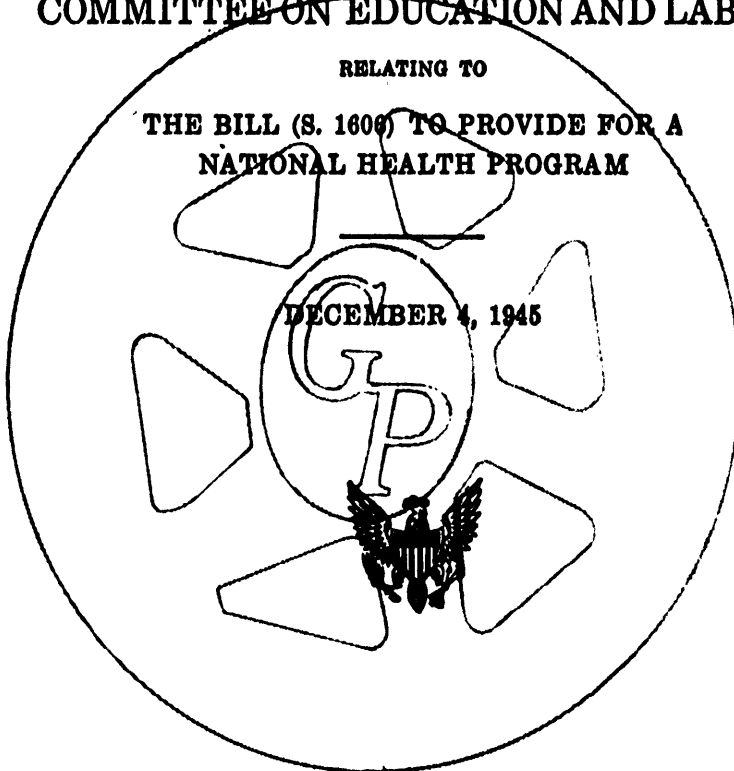
TO THE

COMMITTEE ON EDUCATION AND LABOR

RELATING TO

THE BILL (S. 1606) TO PROVIDE FOR A  
NATIONAL HEALTH PROGRAM

DECEMBER 4, 1945



Printed for the use of the Committee on Education and Labor

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## LETTER OF TRANSMITTAL

DECEMBER 4, 1945.

*To the Members of the Committee on Education and Labor:*

I am transmitting herewith for the information of members of the committee a number of documents giving the views of professional organizations and individual members of the medical profession advocating and opposing health insurance. Some of these documents relate to the health-insurance proposals of S. 1050 and H. R. 3293. However, since the main provisions of S. 1606 and H. R. 4730—the National Health Act of 1945—are identical with the health provisions of the earlier bills these documents are still relevant to the health insurance bill now pending before this committee.

As more documents become available they will be transmitted to the members of the committee for their information.

Sincerely yours,

JAMES E. MURRAY, *Chairman.*





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# **NATIONAL HEALTH ACT OF 1945**

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## **I. BRIEF SUMMARY OF WAGNER-MURRAY-DINGELL NATIONAL HEALTH BILL (S. 1606; H. R. 4730)**

The bill provides for a national health program, including—

### **I. COMMUNITY-WIDE HEALTH SERVICES**

Federal Government provides grants-in-aid to States for (1) public health programs (the existing programs for control of venereal diseases and tuberculosis are not changed), (2) maternal and child health (including crippled children's) services, and (3) medical care of needy persons.

Federal Government will pay between 50 and 75 percent of what a State spends for these programs, with the States having the lowest per capita incomes getting the maximum Federal aid.

State plans to be approved must provide that programs be in effect in all political subdivisions (1) by 1949 for public health programs, (2) within 10 years after date of approval of first State plan for maternal and child-health service, and (3) immediately, for plans for medical care of needy persons.

(1) State plans for public health must provide for extension and improvement of public health work toward achieving nationally accepted standards; (2) State plans for maternal and child-health services must provide that the services and facilities furnished shall be available to all mothers and children in the State or locality; (3) State plans for medical care of needy persons must assure meeting in full the need of individuals for medical care throughout the State as determined in accordance with standards established by the States, and may not impose citizenship or residence requirements or exclude recipients of public assistance under the Social Security Act in determining eligibility for medical care.

Medical care for needy persons may be provided either by the State or local public-assistance agency (through money payments to needy individuals or through payments to persons or institutions furnishing the care), by another State or local agency through mutual agreements, or through the prepaid personal health service benefits program on the basis of equitable payments by a State or local public agency to the personal health services account.

Federal administrative agencies are (1) the United States Public Health Service, for the public health program, (2) the United States Children's Bureau for the maternal and child-health program, and (3) the Social Security Board for the program for medical care of needy persons.

Provision is made for coordination between the administration of the public health, the maternal and child health, and the medical care

of needy persons programs, and between these and related programs including the prepaid personal health service benefits program also proposed by the bill.

## II. PREPAID PERSONAL HEALTH SERVICE BENEFITS

Medical benefits for workers, their wives or disabled husbands, their children under 18 or children of any age, if disabled, and their dependent parents, and for persons receiving retirement or survivors' benefits. Any other person may qualify for the benefits if equitable payments to the personal health services account are made on his behalf by a public agency.

Benefits include all needed service—preventive, diagnostic, and curative—furnished by a general practitioner of the individual's choice (from among all doctors participating in the system), specialist services, laboratory services, and necessary hospital care up to 60 days a year for each member of the family, or 120 days if funds permit. Dental and home-nursing services are also provided but these may be limited in scope at the outset if there is insufficient personnel.

Doctors, dentists, and hospitals may choose the method by which they shall be paid. Payments to doctors, dentists, and nurses shall be adequate, especially in terms of annual income, and having regard for age, specialization, and type of community, and for individual skill, experience, and responsibility.

Provisions are included to assure high quality care, and advancement of medical knowledge and prevention of disease through grants for research, education, and training of medical and health personnel. Priority is to be given to courses for returning servicemen and women.

Benefits are to be administered through the United States Public Health Service with decentralized administration by local areas, and utilizing State (and local) agencies for administration if the State agrees. A national advisory medical policy council, with professional and public representatives, must be consulted by the Surgeon General, and its recommendations transmitted to Congress; local and regional advisory committees are to be established.

All employees in industry and commerce (except railroad workers), agricultural and domestic workers, employees of nonprofit institutions, and all self-employed persons are covered.

A personal health services account is established in the Treasury. Sums sufficient to finance the benefits provided are authorized to be appropriated to this account; from such appropriations there is to be credited to the account (1) amounts equal to 3 percent of wages, up to \$3,600 a year, in covered employments, (2) the cost of dental and home-nursing benefits, and (3) the amount expended for social security beneficiaries who became insured before the bill goes into effect, as well as (4) reimbursements to the account made on behalf of non-insured persons (needy persons, workmen's compensation cases, etc.)

The Surgeon General of the United States Public Health Service and the Social Security Board jointly shall study and make recommendations as to methods of providing dental, nursing, or other benefits not currently furnished and of providing facilities and services for the care of the chronic sick and for prevention of chronic physical and mental diseases.

## **II. ATTITUDE OF AMERICAN MEDICAL ASSOCIATION**

### **A. CONSTRUCTIVE PROGRAM FOR MEDICAL CARE**

#### **AMERICAN MEDICAL ASSOCIATION**

This platform was adopted by the council on medical service and public relations and the board of trustees of the American Medical Association on June 22, 1945. (Journal of American Medical Association, July 21, 1945, p. 883)

#### **PREAMBLE**

The physicians of the United States are interested in extending to all people in all communities the best possible medical care. The Constitution of the United States, the Bill of Rights and the American way of life are diametrically opposed to regimentation or any form of totalitarianism. According to available evidence in surveys, most of the American people are not interested in testing in the United States experiments in medical care which have already failed in regimented countries.

The physicians of the United States, through the American Medical Association, have stressed repeatedly the necessity for extending to all corners of this great country the availability of aids for diagnosis and treatment, so that dependency will be minimized and independence will be stimulated. American private enterprise has won and is winning the greatest war in the world's history. Private enterprise and initiative manifested through research may conquer cancer, arthritis, and other as yet unconquered scourges of humankind. Science, as history well demonstrates, prospers best when free and unshackled.

#### **PROGRAM**

The physicians represented by the American Medical Association propose the following constructive program for the extension of improved health and medical care to all the people:

1. Sustained production leading to better living conditions with improved housing, nutrition, and sanitation which are fundamental to good health; we support progressive action toward achieving these objectives.

2. An extended program of disease prevention with the development or extension of organizations for public health service so that every part of our country will have such service, as rapidly as adequate personnel can be trained.

3. Increased hospitalization insurance on a voluntary basis.

4. The development in or extension to all localities of voluntary sickness insurance plans and provision for the extension of these plans to the needy under the principles already established by the American Medical Association.

5. The provision of hospitalization and medical care to the indigent by local authorities under voluntary hospital and sickness insurance plans.

6. A survey of each State by qualified individuals and agencies to establish the need for additional medical care.

7. Federal aid to States where definite need is demonstrated, to be administered by the proper local agencies of the States involved with the help and advice of the medical profession.

8. Extension of information on these plans to all the people with recognition that such voluntary programs need not involve increased taxation.

9. A continuous survey of all voluntary plans for hospitalization and illness to determine their adequacy in meeting needs and maintaining continuous improvement in quality of medical service.

10. Discharge of physicians from the armed services as rapidly as is consistent with the war effort in order to facilitate redistribution and relocation of physicians in areas needing physicians.

11. Increased availability of medical education to young men and women to provide a greater number of physicians for rural areas.

12. Postponement of consideration of revolutionary changes while 60,000 medical men are in the service voluntarily and while 12,000,000 men and women are in uniform to preserve the American democratic system of government.

13. Adoption of Federal legislation to provide for adjustments in draft regulation which will permit students to prepare for and continue the study of medicine.

14. Study of postwar medical personnel requirements with special reference to the needs of the veterans' hospitals, the Regular Army, Navy, and United States Public Health Service.

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[Editorial from the Journal of the American Medical Association, vol. 129, No. 14, December 1, 1945, pp. 950-953.]

## B. THE PRESIDENT'S NATIONAL HEALTH PROGRAM AND THE NEW WAGNER BILL

Last week the Journal published the message sent to Congress on November 19 by President Harry S. Truman submitting a national health program. On the same day Senator Wagner, of New York, introduced for himself and Senator Murray Senate bill 1606, and Congressman Dingell introduced into the House the same version of the new Wagner-Murray-Dingell bill. Obviously a number of conferences between those interested must have preceded the coordinated action that occurred. Senator Wagner accompanied his introduction of the measure with another opening statement, a brief summary of the health provisions and a long series of questions and answers about the prepaid medical care provisions of the National Health Act of 1945. The language of the President in his message to the Congress and of Senator Wagner in his statement to the Senate and the language of the measure itself are the same trite locutions that the advocates of Federal compulsory sickness insurance have used for these many years in trying to force these proposals on the American people. According to Arthur Sears Henning, "the compulsory health insurance plan is chiefly the

brain child of Isidore S. Falk, research director of the Social Security Board, and Michael M. Davis, a member of the CIO political action committee."

Elsewhere in this issue appears an analysis by the bureau of legal medicine of the American Medical Association of the changes in the latest version of the Wagner-Murray-Dingell bill from that introduced previously. Mr. Wagner in his opening statement again informs the Senate that this bill is the result of the constructive suggestions of many outstanding medical authorities and of labor, farm, consumer, and health organizations interested in improving the Nation's health. Neither the President nor Mr. Wagner nor the Social Security Board made the slightest attempt to consult any representatives of the American Medical Association, which now embraces in its membership more than 125,000 American physicians. Typical of the kind of government that the bureaucrats would force on the American people is this technique of consulting advisers who are known in advance to be in complete agreement with the persons whom they are supposed to advise and of studiously avoiding anyone who might offer a contrary opinion. This is government by minority with a vengeance.

The insidious strategy that has been employed in recent years, leading toward culmination by approval of the President of the United States, is clearly apparent to those with an understanding of what has been going on. Since the time when Michael Davis and his associates engineered the formation of the Committee on the Costs of Medical Care down to the present, a gradual enlistment has been secured in behalf of socialized medicine of every agency that could be induced to combine in a movement toward socialization of the American system of government. Around their banner have rallied the members of the so-called Boas' Physicians Forum, certain doctors of philosophy in the field of economics and sociology, the socialist element in the American Public Health Association and those employed in governmental health agencies who thirst for increased power and expansion of the bureaus that they serve. Let the people of our country realize that the movement for the placing of American medicine under the control of the Federal Government through a system of Federal compulsory sickness insurance is the first step toward a regimentation of utilities, of industries, of finance, and eventually of labor itself. This is the kind of regimentation that led to totalitarianism in Germany and the downfall of that nation. Its prime consideration is deduction from the pay of the worker and taxation of the employer so that the Government does for the people most of the things that our people in the United States have been accustomed to do for themselves. The time may yet come when the American worker, as was the case with the German worker, will have more deductions from his wages than "take home" pay.

#### "SOCIALIZED MEDICINE" AND FREE CHOICE

In the President's message to the Congress and in the material written for Mr. Wagner by those whom he employs and consults in the preparation of his proposals, constantly reiterated is the statement that these proposals are not "socialized medicine." The first of Mr. Wagner's questions and answers is concerned with this question in

semantics. Worse than socialized medicine is "state medicine." In any system of state medicine the government collects the funds available, manages the service, and distributes the payments. Is not this what the Wagner-Murray-Dingell bill would accomplish? True, in the proposed legislation for a Federal system of compulsory sickness insurance, patients are told that they will have free choice of doctors; doctors are told that they will have the right to refuse any patients; but the bill provides that the Surgeon General can limit the number of patients that a physician will see, and that the Surgeon General will provide other physicians when too many patients select one or more of the physicians in a community. The measure mentions free choice of doctor for the patient, but it is free choice within limitations. It is free choice of the doctors who are willing to work under the system. It is free choice if the doctor is willing to work under a fee bill set up by the Government. It is free choice if the doctor is willing to accept a payment of so much per person per year for his services. It is free choice if the doctor is willing to work as a salaried member of a group. It is free choice if the doctor is willing to abide by a majority vote of the doctors licensed to practice in his community. What kind of free choice is that?

Senator Wagner has always insisted that compulsory health insurance—really sickness insurance—is not socialized medicine. Actually the proposals involve both socialized medicine and state medicine. The American people are entitled to straightforward, honest statements from their representatives as to what such proposed measures would do to them and to their physicians. They have not had such a straightforward statement either from the President in his message or from Senator Wagner in his statement to the Congress.

#### THE STATISTICS

In opening his message to the Congress, President Truman referred again to the rejections of registrants under the draft and to the rejections of women who applied to the Women's Army Corps and other women's services. Every fundamental principle of the scientific interpretation of statistics has been violated by the proponents of Federal compulsory sickness insurance in their utilization of these figures as propaganda for the measures they proposed. The facts have been provided in several previous editorials in the Journal. One needs only to recognize that the standards of physical fitness for military service changed greatly from the army of preparedness to the end of the war. Men who were rejected as physically unfit for military service in the first year of war were accepted as quite fit for complete service or for limited service in the later years of the war. Furthermore, none of the proponents of this legislation have ever admitted frankly, as they should if they are interested in an honest scientific statement of the facts, that a tremendous number of those rejected as unfit could not be made more fit by any knowledge available to modern medicine today.

In his questions and answers presented to the Congress, Senator Wagner again challenges the statement that health conditions and standards of medical service in the United States are higher than in any other large country in the world. Here are more tricks with words. The figures for New Zealand have often appeared better than



those of our country, but New Zealand is quite different from the United States and not in any sense of the word comparable. And even if it were comparable, the statistics for New Zealand concern its white European population and carefully avoid citation of its colored and native population. As we go to press New Zealand's system of socialized medicine reportedly faces failure and bankruptcy. Mr. Wagner even challenges the figures for life expectancy in the United States. Let him consult the most recent figures prepared by the leading life insurance companies in this country, which have a financial stake in the life expectancy of the people; he will discover how far ahead the United States really is of any other country in the world with or without a national compulsory system of medical care.

#### FEDERAL AID FOR HOSPITALS

The President's program includes five features. First is the proposal to grant Federal aid for the building of hospitals and health centers throughout the Nation. Both the American Medical Association and the American Hospital Association have approved the principles of the Hill-Burton bill, which make this proposal effective. Senator Wagner in his statement to the Congress reminds us that he himself introduced a hospital construction bill in 1940. He has now eliminated from the new Wagner-Murray-Dingell bill the section in the previous draft which concerned hospital construction. This at least is fortunate for the American people because the provisions of the Hill-Burton bill, as modified by the Senate committee which conducted the hearings and which has reported the bill favorably to the Senate, are much more wise and much more scientific than the proposals of Wagner, Murray, and Dingell. Under the Hill-Burton bill money will not be spent until the need is shown by a survey conducted in the individual State. Furthermore, State organizations will be developed which will have the responsibility for allocation of funds and the control of the expenditure of funds. The place of the Federal Government will be to act as custodian of the funds and to provide the funds when adequate evidence of their need and proper utilization is supplied. Incidentally, this measure recognizes that some areas of the country may need funds much more than do others, and beyond the ability of the individual State to match any Federal appropriation.

#### MATERNAL AND CHILD HEALTH SERVICES

The second recommendation by President Truman is for an expansion of maternal and child health services. Apparently President Truman failed to take into account the pending Pepper bill for maternal and child health, which was analyzed in an editorial published in the Journal on November 10. Senator Wagner in his statement to the Senate does recognize the existence of other proposals. The Wagner-Murray-Dingell bill would make increased grants-in-aid through the Children's Bureau to the individual States for maternal and child health and crippled children, the States developing their own plans, which, of course, would have to have the approval of the Chief of the Children's Bureau. Here the grants are made variable according to the established need in the individual States. The Wagner-Murray-Dingell bill requires that the Chief of the Children's Bureau enter into

agreements or cooperative working arrangements with the Surgeon General of the Public Health Service to insure coordination in the administration of programs and services in this field. This at least is a recognition of the fact that Federal coordination of health activities is a fundamental need in our Government at this time. The Congress will soon give authority to the Chief Executive to transfer various agencies in order to secure coordinated action and to bring about unified policies. The American Medical Association has recommended again and again and again that the No. 1 step necessary in coordination of health activities is removal of the Children's Bureau from the Department of Labor to the United States Public Health Service in the Federal Security Agency. Previous Presidents have apparently been unable to accomplish this highly desirable objective. The American Medical Association favors the utilization of Federal or State funds for the extension of maternal and child health services where needed.

President Truman also urges an extension of public health services throughout the United States. At present less than half the counties in the United States are provided with full-time public health service. Perhaps some of our counties could never utilize a full-time public health service efficiently; groups of counties could, of course, cooperate. Nevertheless the American Medical Association has been among the leaders of the Nation in urging that adequate public health service be made available in every community in our country.

#### EDUCATION AND RESEARCH

Confusion again prevails when the proposals of the President's message and of the Wagner-Murray-Dingell bill are read in connection with the proposals of the various measures for establishing a national science foundation. This Mr. Wagner recognizes in his statement to the Congress; he points out that the Senate Committee on Military Affairs has before it legislation providing for the promotion of medical research and professional education. He indicates that these proposals remain in his revised National Health Act because he wants to help promising individuals without financial means to get a medical education, and he wants to overcome "the restrictions which the medical schools apply particularly to persons of minority groups." For these purposes the sums of \$10,000,000 the first year and \$15,000,000 the second year are mentioned. Incidentally, the Senator wisely recognizes the necessity for training adequate personnel in the field of public health if progress is to be made in that field. Nevertheless the Congress would do well to place in some single agency all of the various programs allocating funds for training personnel in the field of research, medicine, the public health, the basic medical sciences and related fields of study. Scientists throughout the Nation are agreed on the desirability of a national science foundation. Physicians favor increased research on cancer and on mental disease and indeed in every medical field in which research could be helpful. They do feel, however, that any national science foundation should be directed by a competent board of scientists, who could coordinate research and education. Apparently the present administration seems to prefer a national science foundation which would be headed by a politically appointed director. Apparently Wagner,

Murray, and Dingell seem to prefer a system in which the Surgeon General of the United States Public Health Service would allocate funds to medical schools, research institutions, and similar agencies that meet this approval. The movies have a czar who directs and coordinates their activities in certain fields, but they can remove him when they wish to do so and they are free to resign from his support when they wish to do so. Similarly baseball has its czar. Now apparently our Government wants a czar for medicine and another czar for research, but there is no way in which those who would be compelled to subscribe for the establishment of the system and for those who would be compelled to work under the system to resign. Their freedom would become a thing of the past.

Incidentally, in his statement on medical research and education, Senator Wagner has one quite revolutionary paragraph. Under the Constitution of the United States the control of medical practice is within the province of the individual States. Here is the statement of Senator Wagner:

State licensure laws are so complex, so lacking in uniformity, and so obstructive of interstate mobility of qualified practitioners that some Federal legislation is necessary to bring order out of this chaos. There are no medical schools in some States, and measures to remedy this defect should be considered. Finally, the discrimination which most medical schools practice against student applicants from minority groups requires congressional consideration and action.

Regardless of whether or not some of the abuses to which the Senator refers exist, the Senator finds only one possible remedy—compulsion by the Federal Government and removal from the individual States of their right to control their own policies. Furthermore, has he made the slightest possible investigation to find out whether or not every State in the United States can support and operate successfully a modern medical school? Has he considered the necessity for teachers, for pupils, for patients? One is reminded of the State which built with Federal funds a hospital for crippled children that exhausted the needs of a hospital for crippled children in that State within 2 years.

#### COMPENSATION FOR LOSS OF EARNINGS DUE TO SICKNESS

The fifth proposal in the President's program and in Senator Wagner's measure is compensation for loss of earnings due to sickness. The American Medical Association through its house of delegates has consistently favored such insurance. Most strange among the changes in the present measure offered by Wagner, Murray, and Dingell from their previous promulgation is the failure to indicate anywhere in the proposed measure the taxation to be provided on the worker and on the employer to provide funds for this measure. True, the President in his message mentions 4 percent on the first \$3,600 earned by an employee, but the measure itself makes no such mention. Perhaps the mention was avoided deliberately by Senators Wagner and Murray and by Congressman Dingell so that the bill could be referred to the Senate Committee on Education and Labor, of which Senator Murray is chairman, rather than to the Senate Committee on Finance, to which the previous measure was referred. This may serve to secure hearings on the legislation and thus to keep it alive rather than to permit it to sink into the innocuous desuetude that was the fate of the previous measure.

## EVILS OF COMPULSORY SICKNESS INSURANCE

Many of the answers included by Senator Wagner in the questions and answers submitted by him to the Senate are denials of the charges repeatedly made against his proposals by those who wish to see the principles of initiative, democracy, and freedom maintained in American medicine. Thus he categorically denies that his measure "will destroy the private practice of medicine," that it will place the medical profession "under the direction of one man, the Surgeon General of the United States Public Health Service," that "the National Advisory Medical Policy Council will have no authority," that "the hospitalization provisions in the bill" will "destroy the voluntary hospital system," that "medical education will be controlled by the Surgeon General," that "the bill will plunge the physicians into political slavery," that "people will be obliged to take any doctor the Surgeon General tells them to," that "the Surgeon General of the Public Health Service" will have "the power and authority to designate which doctors can be specialists." The Senator by sophistic argument and smooth phrases categorically denies all of these charges against this measure; the Journal of the American Medical Association now insists that every one of these charges against the measure is valid and that the actual text of the measure itself is the proof of that validity.

No one will ever convince the physicians of the United States that the Wagner-Murray-Dingell bill is not socialized medicine. By this measure the medical profession and the sick whom they treat will be directly under political control. By this measure the great system of private hospitals and community hospitals that have grown up in our country will depend for their continued operation on funds paid to them by a Federal Government agency. By this measure the philanthropic efforts for the care of the sick, which have been the pride of our Nation, will be forever deterred. Through this measure competent young men who would enter the medical profession will be forced to seek other fields of action still remaining under our democracy which still permit the exercise of individual initiative and freedom of thought and action. By this measure doctors in America would become clock watchers and slaves of a system. Now, if ever, those who believe in the American democracy must make their belief known to their representatives, so that the attempt to enslave medicine as first among the professions, industries, or trades to be socialized will meet the ignominious defeat it deserves.

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### C. THE AMERICAN ASSOCIATION AND MEDICAL CARE<sup>1</sup>

Dr. LOUIS H. BAUER, Chairman

Council on medical service and public relations of the American  
Medical Association

I am very glad to have an opportunity to discuss the subject of medical care today. We are all delighted that the United States Chamber of Commerce has taken such a keen interest in the subject.

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<sup>1</sup> Reprinted from Social Security in America, Chamber of Commerce of the United States, 1944, pp. 96-100.

The American Medical Association has this subject very much at heart. While the association has been accused of being reactionary and obstructive, it is an unfair accusation. The association has been the victim of a great deal of propaganda, some through ignorance and some, I fear, through malice. For example, the association has been accused of opposing group practice. The charge is a false one. There are many groups operating in the United States, approved by organized medicine and members of these groups are and have been officers in the national and State medical bodies. The American Medical Association has only opposed those groups which were so organized that they could not possibly deliver good medical care and which were organized by irresponsible parties who were not interested primarily in the welfare of the patient. The association has also been accused of opposing prepayment insurance plans. This again is not true. The association has only opposed those plans which were not sound and could not deliver good medical care. There are large numbers of such plans in operation which have the approval of national, State, and county organizations.

Realizing the necessity for further action, however, the association last June set up a new council on medical service and public relations whose duties are as follows:

1. To make available facts, data, and medical opinions with respect to timely and adequate rendition of medical care to the American people;

2. To inform the constituent associations and component societies of proposed changes affecting medical care in the nation;

3. To inform constituent associations and component societies regarding the activities of the council;

4. To investigate matters pertaining to the economic, social, and similar aspects of medical care for all the people;

5. To study and suggest means for the distribution of medical services to the public consistent with the principles adopted by the house of delegates; and

6. To develop and assist committees on medical service and public relations originating within the constituent associations and component societies of the American Medical Association.

In the exercise of its functions, this council, with the cooperation of the board of trustees, shall utilize the functions and personnel of the bureau of legal medicine and legislation, the bureau of medical economics, and the department of public relations in the headquarters office.

The council feels that one of its outstanding duties is to evolve a system of medical care which will cover all the people and be in accordance with the traditions of American medicine as to high standards of medical care and the American tradition of free enterprise.

There is no evidence that the American people want different doctors or a different system of medical care. They merely want what is available at a lower cost and want it more widely available. They want the privilege of choosing their own doctor. They do not want to be regimented in medical care.

To quote from the general policies of the council:

The council on medical service and public relations recognizes the desirability of widespread distribution of the benefits of medical science; it encourages evolution in the methods of administering medical care, subject to the basic principles

necessary to the maintenance of scientific standards and the quality of the service rendered.

It is not in the public interest that the removal of economic barriers to medical science should be utilized as a subterfuge to overturn the whole order of medical practice. Removal of economic barriers should be an object in itself.

It is in the public interest that the standards of medical education should be constantly raised, that medical research be constantly increased, and that graduate and postgraduate medical education be energetically developed. Curative medicine, preventive medicine, public-health medicine, research medicine, and medical education, all are indispensable factors in promoting the health, comfort, and happiness of the Nation.

There are many emergency situations which must be met. These situations are caused by the general shortage of civilian medical personnel and by shifting industrial populations. Because of the temporary nature of these emergencies, the measures adopted should be temporary and may vary from time to time and from place to place as the situation demands.

The private practice of medicine as now conducted, with certain modifications, will meet the needs of a large proportion of the population. Costs of medical care under this system can be met by those in only moderate financial circumstances, by (1) the use of voluntary group hospital insurance now protecting about 14,000,000 people, but it should protect several times that number and extension of this service should be made so that it is available to anyone who desires it; (2) the use of voluntary medical-expense indemnity insurance. A number of these plans are in operation. Many of them cover only surgical and obstetrical care. A few cover all medical expense, but the public has shown, to date, little interest in such plans and there is little actuarial experience on which to base such plans. Hence, many plans which started out with the idea of giving complete coverage have altered the coverage to the limited nature mentioned above. The public must be sold on these plans and educated in the costs of medical care. There is no doubt that complete medical coverage can be obtained by such plans at a considerably lower rate than would be required in any compulsory plan. Progress has been slow, but experience is being acquired, and changes will gradually be made in these plans as indicated by that experience. Criticism has been made that voluntary plans will not work. They have not yet been going long enough to warrant such a criticism. It is often said that the voluntary plans in England were unsatisfactory. There is no relationship whatever between the so-called voluntary plans or lodge practices in operation in England prior to the adoption of the compulsory sickness plan, and the voluntary plans being developed in the United States. It takes time to develop any new system of insurance, and the entire habits and customs of a country cannot be changed overnight.

Each State medical society should foster such voluntary plans and assist in their advertising. Joint arrangements should be made with the hospital group insurance so as to avoid duplication of selling costs, but hospital care and medical care require different policies. To start with it may be well to cover only surgery and obstetrics as these are the most catastrophic financial burdens. As experience develops, further extension of these plans will be possible. It is doubtful if a

national plan is feasible because of the differences in local situations. Consideration of inclusion of nursing care in the voluntary plans must be given careful study, also, as this is often one of the most expensive items of medical care. The provision of certain expensive therapeutic agents at a low cost must be considered. The State, in many instances, provides smallpox vaccines, diphtheria toxoid, and antitoxin, and, in some cases, the various sera and sulfa drugs. The Federal Government has provided radium. A wider extension of this service for the lower-income groups is essential. Oxygen is a valuable therapeutic agent and it is being more and more widely used, but it is expensive. Possible State subsidy on this is to be considered.

The use of group practice should be studied further in local communities. Grouping of doctors to save office rent and equipment without further association is a help. Groups organized for diagnostic purposes have not proved too successful except in certain isolated instances. The group method, however, has proved practicable for mushroom industrial populations; and where there is a shortage of doctors or where the industrial population is resident in a restricted area it may be the answer to the problem. It has not yet been tried in rural areas and its feasibility there is doubtful but its use as an experiment is justifiable, and State and county organizations are urged to conduct such experiments to determine its value.

The question of the development of diagnostic centers needs careful study. In some areas this may be feasible and productive of a less expensive, yet excellent, type of medical care. Again, States and counties are urged to foster such plans on an experimental basis.

Different methods will be found to be satisfactory in different areas.

The indigent are in most areas well taken care of and no change seems to be indicated in their case, except to extend care to those areas not covered. The State will continue to provide hospital care and the doctor will continue to donate his services. There is a group, however, which is above indigency and below self-sufficiency which needs help. The insurance schemes mentioned previously and the provision of free or less costly therapeutic agents, the use in some cases of diagnostic centers will help them, but there will still be a group that is not protected, and some other plan must be found for them. Until a better plan is available, the extension of the medical relief system to them will afford a temporary answer. The law in some States permits this but it is inoperative.

A steady evolutionary change along the lines already outlined will meet the needs of the public and no revolutionary change as suggested in the Wagner-Murray-Dingell bill is justified. The latter would provide mass medicine of an inferior character under the absolute dictatorship of one man. It would interpose a third party between the doctor and the patient and the doctor would be responsible to that party and not to the patient. He would become restricted in his therapeutics. He would spend much of his time with reports. There would be no inducement to practice good medicine, and he would be subject to political buccaneering. It would overthrow everything we now have and set up a completely new system practically overnight.

More specifically, this bill provides the following:

1. It practically does away with the private practice of medicine as now carried on. Medical care will deteriorate from a highly personalized service to an impersonal, regimented service under a Government bureaucracy.

2. It subjugates all doctors and all patients to the authority of one man, the Surgeon General of the United States Public Health Service, who prescribes fees, determines who are specialists, prescribes under certain circumstances whom the patient can see, whom the doctor can have as a patient, and to what hospital he is to go, although free choice is supposed to be provided in most instances.

3. Although the bill provides for an advisory council, to be appointed by the Surgeon General, there is not one word in the bill that requires a physician to be appointed, and even if all members of the council were physicians, the council has absolutely no authority—it is advisory only.

4. It provides for a study of dental and nursing care, apparently with a view to regimenting them also at a later date.

5. It calls for grants-in-aid to medical education. This will result in the Government eventually controlling our medical schools. It will remove the incentive that stimulates the student to acquire the best medical education obtainable, by offering him a regimented practice, federally supervised and controlled.

6. It provides for grants-in-aid for medical research. The Surgeon General again is the one who will decide to whom these grants will be given, and whether or not the contemplated research is worth while.

7. It calls for the expenditure during the first year of \$3,048,000,000, only a portion of which will be for medical care and this money is to be obtained by increase of social security taxes from employer, employee, and self-employed, and applies these taxes to nearly all the people. The sponsors of the bill claim that there will be no politics connected with the plan. I ask you if you can conceive of any plan involving the expenditure of over \$3,000,000,000 of Government funds in which politics will not play a part, and a large part at that?

Compulsory sickness insurance has, in no instance, given good medical care. It has resulted in higher morbidity and mortality rates than we have in the United States. It has resulted in an increase in the preventable diseases, and it has fostered malingering.

In Germany, before the war, the lay employees of the health bureau outnumbered the doctors working for it. In England, the general practitioner (the only service given under the English scheme), has become merely a certificate writer. As one English doctor has said, the "certificate must satisfy the patient, satisfy his own tattered conscience, and at the same time keep the doctor out of the hands of the general medical council."

We are earnest in our endeavor to provide good medical care for all the people but we believe this can best be done by gradual evolution and modification of our American system rather than by discarding all we have now in the way of the best health record in the world and substituting what is essentially a foreign system. In all probability, when found, there will not be one answer, but several answers.



**D. NEW MEDICAL CARE PROGRAMS AND THE AMERICAN MEDICAL ASSOCIATION<sup>1</sup>**

**R. L. SENSENICH, M. D.,** trustee, American Medical Association

New medical care programs cannot be discussed intelligently without giving some consideration to what we now have, the factors that have influenced progress to this point, and what needs are to be met. For that reason a brief survey of the situation should be helpful.

The best possible medical care for all the people has been the constant aim of the medical profession of the United States throughout the years. The present standards of medical care in America are higher than in any other country in the world.

The remarkable achievement of present high standards of medical education and medical care has been accomplished by the profession itself. The American Medical Association and its constituent and component societies have provided the means for study and action to those ends. The individual would be helpless. The uninformed public, the economic planner without experience in giving medical care, and the politically minded public official could be more harmful than helpful. In fact, higher standards of medical education, advancement of scientific medicine, improvement of hospitals and medical equipment, and evaluation of new drugs and techniques have been accomplished by the councils of the American Medical Association and by its constituent State associations against indifference in government circles.

Medical service in illness, preventive medical measures, attention to nutrition and immunization in childhood, through education and voluntary efforts, are more advanced in the greater portion of the United States than in comparable European groups having compulsory sickness insurance plans.

The medical profession has been justly proud of its cooperation with all agencies, governmental and private, in giving medical care to those in need of care and unable to pay for that service. Services and medicines to the sum of many millions of dollars have been given without charge by physicians each year without public statement or record. No one in need of medical care and making that need known to the proper officials of government or private agencies or directly to physicians should have failed to receive medical service. An inquiry concerning this matter was addressed by the American Medical Association to public officials and charity agencies of towns and ministers of local churches and other citizens in smaller areas throughout the United States. Only a few instances of inability to obtain needed medical care were reported and the reasons for these failures were not clear. Others who should have had medical care may not have sought it because of the cost.

Although the number of these is apparently not as great as is often estimated, the American Medical Association is interested in determining the causes of these unnecessary hardships and in assisting in correcting them.

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<sup>1</sup> Reprinted from *Health Insurance in America*, Chamber of Commerce of the United States, 1945, pp. 17-25.

It is recognized that certain areas do not have physicians or medical facilities in which good medical care could be given. Sufficient education in matters of health are often lacking and services which might have been helpful are not sought. There are no available facts from which any approximation may be made of the actual effect of this deficit upon the health of the public in these areas other than the prevalence of nutritional disorders and of communicable disease, notably tuberculosis and syphilis.

The American Medical Association began years ago to study the needs for medical services and the inadequacies of medical facilities. Roughly the subject may be considered under four subdivisions:

I. Provision of medical facilities and location of physicians in areas not so supplied.

II. Medical care of the indigent and those having chronic illness.

III. Medical care of those of low income who are able to pay for ordinary medical services but upon whom an unusual expense because of illness creates hardship or requires protracted payments.

IV. Medical care of those who are well able to care for themselves financially and do not desire any interference with their program of living. This group does not need attention other than that the medical profession must continue to maintain high standards of medical care for them as well as other groups.

Included within these groups are several millions of individuals who, because of religious beliefs or for other reasons, do not consult physicians or desire medical care. So long as these people do not expose others to communicable disease this freedom may not be abridged.

This subject could be still further subdivided but for brief discussion this grouping directs attention to the major points to be considered.

I. Provision of medical facilities: The establishment of hospitals and laboratories and other medical facilities in areas not having adequate provision to meet medical needs meets with general approval. Grants of Government aid to areas where need is demonstrated has also been generally approved. We do not have time here to discuss the details of determination of needs, or of the management, local or national, of these facilities. Nursing service and better community health protection may be the items of greater need. Education of the public in health matters and in utilization of modern facilities in the treatment of illness are necessary. It will not be difficult to get physicians to locate in areas where facilities and economic status make good medical care possible. But it must be pointed out that the needs of these inadequately supplied areas cannot properly be used as a reason for subjecting to national regulation the major portion of the country having more advanced standards and facilities. The areas of higher standards will progress better under their own planning than they would under any governmental pattern.

II. The medical care of the indigent and chronically ill: Concerning this group it would seem that there could be no difference of opinion. They should be cared for at governmental expense from tax funds. Indigency results from many conditions, among them economic causes in which illness is only incidental, factors of habit,

thriftlessness, and subnormal mentality as well as those whose indigency is primarily due to chronic illness. Cases of indigency of economic origin and those of constitutional inadequacies, crippling or chronic disease, cannot properly be loaded upon insurance funds. These funds are accumulated from regular premium payments as a means of advance budgeting against the average incidence of illness as it may occur in those mentally competent and presumably well. To include the chronically ill would force unjustifiable burdens upon the shoulders of this group and also result in deterioration of medical services available to them. The economic casualties, accidents of birth, constitutional inadequacies, and crippling, should be supported by the whole taxable group and not from the funds of a limited insured group.

Study of the manner in which governmental agencies have met the indigent need for medical care reveals what in many respects has been the most disappointing finding. In many cases the medical care of this group has been provided almost entirely by nongovernmental agencies or charitably inclined individuals and physicians who gave their services without charge. The urge to provide political sales talk by a record of low cost to the taxpayers apparently prompts many public officials to set up evasive formulas by which indigency is determined. The same formulas are used to avoid responsibility for medical care even when the law permits a broad construction with respect to care in illness. If all governmental agencies would meet the medical needs of the indigent as they are in most instances directed by existing law or as could be provided by minor legislation, there would not be any indigent medical-care problem.

III. Medical care to those of lower income who are able to pay for medical services in the average illness but upon whom an unusual expense of illness creates hardship or requires protracted payments.

The American Medical Association began the study of the needs of this particular group years ago. The individual in this group may be described as generally appreciative of good service and therefore selective in his choice of the physician in whom he has confidence. He is an individualist in his thinking and objects to interference with his own planning. Despite the absence of a large financial reserve he gets by very well. Although the unpredictable illness may require budget payments, he pays debts incurred within a reasonable time. In this the physician helps him, and surgical or other fees are generally adjusted to his ability to pay within a year. In fact the illness, if not unusually expensive, may be much less burdensome than his payments upon the new automobile, refrigerator, radio, and household furniture that will be repossessed by the seller if he fails to make payments as promised. Credit authorities state that the aggregate obligations of the group for these purchases sometimes due to high-pressure sales are very large in amount. As compared with them, the debts incurred for medical services are negligible.

To meet the particular problem of catastrophic illness and its effect upon this group, insurance plans in operation all over the world were studied by the American Medical Association to explore the possibilities of some mechanism by which budget payments into an insurance pool might provide funds for medical needs as they develop.

Government compulsory plans in other countries were studied as to advantages, disadvantages, tendencies to loss of the importance of

the individuality of the patient, and to deterioration of quality of the service. Political manipulation and exploitation for political jobs and diversion of insurance funds to various purposes were reported.

Various constituent State medical associations also studied the possibilities of insurance plans as related to the medical problems of their respective States. Plans were proposed for the purpose of gaining actuarial experience and observing the public reaction to such insurance.

The American Medical Association approved and encouraged well planned study and experimentation in the use of insurance plans whereby budgeted payments could be accumulated to be available for the payment of medical care at the lowest possible cost without impairing the quality of the service. Twenty States now have such plans in operation or are in the process of preliminary study, enabling act or experimentation sponsored by the State medical society. In addition to these, 38 States cooperate with the Farm Security Administration. Most of the plans of State societies are now on a sound financial basis. The service offered varies but changes are brought about as actuarial information is gained. Some of the plans have had a number of years of experience. However, the major portion is less than 4 years old. As a consequence there has not been sufficient time for the public to become thoroughly familiar with this insurance method. Because of the lack of actuarial experience, many of the plans have not accepted more than 1,000 new subscribers per month. Despite this short period of time, one of the plans has approximately a million members and another one only slightly less than a million. Other State plans have been growing in number and the total membership is now reported in excess of 3 million. This does not include hospital insurance. Also it does not include any of the plans connected with industry, in which it has been estimated that more than 16 million are covered by some kind of group insurance to protect against sickness costs.

The types of insurance vary—some plans being entirely service type plans and others indemnity type. The service type in general have upper income limits upon those who can secure membership. The income limits generally specified are not to exceed \$2,400 annually. The indemnity type are not limited to any special income group.

Any prepayment plans in which funds are pooled to meet future needs are in essence a type of insurance and most States require substantial reserves deposited with the State insurance departments to guarantee the fulfillment of the contracts. Special legislation has been enacted in some States under which only a very minimum of reserve deposit is required from certain organizations. The guarantee that the service will be rendered by participating physicians is accepted in lieu of the larger reserves required of other types of insurance. Many physicians have participated in these service plans, in a desire to cooperate in the experimental study of the possibilities of this type of insurance, who would not participate if the plan placed the major portion of their practice on that basis.

The indemnity type of insurance has the advantage of being more elastic, more universally applicable and has been generally accepted by the profession in the many types of health insurance which have been operative throughout the years. It leaves the patient in control of selection of his physician.

Some of the State plans in operation are limited to surgical and obstetrical service. Others provide both medical and surgical services to male and female and are closely integrated with existing hospital plans so that the purchaser of such insurance has coverage of all the phases of medical care.

These plans seem to be not only quite satisfactory but increasing in popularity despite the fact that in most instances there has been no active sales effort. In a number of States, plans are being made to extend the protection to illnesses not now included.

Public opinion surveys in communities having these mutual types of insurance and in other communities not having insurance have indicated a high percentage of individuals who desire some kind of insurance protection. The same individuals, however, are reported to have voted strongly against government compulsory sickness insurance.

Some years ago conferences were held by representatives of the American Medical Association with representatives of organized labor with reference to medical care in industry and to the families of the employed, giving special thought to the possibility of some insurance plans. A vice president of one of the larger units of the American Federation of Labor spent some time in Europe representing the Federation of Labor in studying compulsory sickness insurance plans. On his return, his recommendation was definitely against the operation of such compulsory plans. He reported many observations of the unsatisfactory character of the service and its administration under government control. Labor has repeatedly stated its objection to the contract doctor.

The council on industrial health of the American Medical Association, in conference with representatives of the American Federation of Labor, the Congress of Industrial Organizations, the National Association of Manufacturers, stock and mutual insurance companies, the Public Health Service and other agencies, has come to agreement upon far-reaching plans for health in industry. These plans provide for health education including nutrition, prevention of illness, physical examination, confidential records, and selective placement in suitable jobs, confidential consultations between the industrial surgeon and the private physician of the patient in matters relating to the health of the employee and simplified processes of adjustment in compensable illnesses and injuries were approved.

Many of the employees are now covered by hospital insurance to which premiums the employer and employee contribute. In a number of industries these health measures, as outlined, have been so satisfactory to both parties that the possibilities of extending the coverage to the families of employees is being discussed. The attitude of labor toward governmental compulsory insurance plans at this time has been variously stated by some representatives of labor organizations. Where individuals and groups of members of labor organizations understand the implications of compulsory Government sickness insurance, the attitude has not been in favor of compulsory Government insurance.

The American Medical Association has for many years given study to the costs of good medical care with a view to keeping that care available to the low-income group without deterioration of quality. Better or-

ganization and higher standards in specialization with proper facilities for good work at a minimum charge have been encouraged. Group participation in the use of office facilities, also the grouping of medical men in the various specialties of medicine in the joint ownership of facilities, commonly referred to as group medicine, are being tried.

At the close of World War I there was heightened interest in group medicine and many organizations were established in various parts of the country. Not all of these group organizations continued as operating units over any great period of time. Some of the physicians continued to occupy adjoining offices although they practiced as individuals not professionally associated. It would not be helpful to discuss the varied reasons for these failures, but it must be remembered that the individual patient is still an individual. He will place his confidence in Dr. Jones and will have nothing to do with Drs. Smith and Brown. No one can deny him the right of the choice of his confidential adviser.

The effect upon the cost to the patient in group practice is apparently not impressive. Some costs may be moderately reduced in various group organizations, but it must always be borne in mind that the practice of medicine is an individual service and the physician can give the best medical service to only a comparable number of patients no matter in what type of organization he is working.

Medical science has made remarkable progress. The average of human life has been greatly extended and the quality of life in terms of physical and mental health and happiness has been made better in similar proportion. A recent report by an insurance company, based upon a study of causes of death, estimated that more than 1,000,000 lives have been saved in the past year as compared with the average annual mortality over a long period, due to progress in the medical treatment of certain diseases. However, the very progress that has made possible this remarkable prolongation of life and better levels of health has made medical service more costly in facilities required—hospitals, special equipment, special laboratory tests, and trained nurse care, in addition to the closest observation and care by physicians. Today good medical care cannot be cheap.

Every possible plan of improvement of the methods of distribution of medical care is constantly being studied.

#### CONCLUSIONS

I. Government aid should be extended in the provision of medical facilities in areas where need is determined. In the determination of that need the local community should have a voice and should have the control and operation of facilities thus provided.

II. The indigent should not be included in any plan of insurance even though payments be made by the Government, because of the abnormal concentration in that group of the congenital defectives, crippled, and chronically ill. Those who have insufficient income to live properly under healthful conditions would also fall in the same high liability group. Both would become unfair burdens upon the pooled funds contributed for insurance purposes by those living under average conditions with normal nutrition, reasonably healthful conditions of employment, and normal housing.

The economic needs of this group should be met from general tax funds. The American Medical Association is now giving thought to

the problem of the chronically ill. Many of these patients should have treatment not available in the home. Many require nursing care that is beyond the physical capacity of the family to provide. Probably some new kind of institution will be necessary to meet this need. The long duration of chronic illness makes it impossible to take care of them in hospitals whose facilities are necessarily geared to the needs of acute cases.

A better approach to the problems of the indigent can no doubt be worked out through cooperation of the responsible public officials with the medical profession.

The statement frequently repeated that one third of the public are unable to have needed medical care because of insufficient income is a broad generalization based upon economic variables that change constantly. Certainly it is not true now and there are so many undefined and changing factors that it could not be proved at any time. It is noteworthy that in the group of those of reported low income were many millions of small farmers who obtain almost all of their living needs from their farms. Among them, in areas studied, indigency was almost unknown and health and comfort levels were high despite the small income in money. At any rate, such economic disability as actually exists in the group should be adjusted from an economic basis and not be placed as a burden upon the shoulders of others under some misleading type of insurance. Incidence of illness is influenced greatly by economic status, nutrition, clothing, housing, and conditions of employment. Economic causes of illness require economic treatment and are not corrected by medical treatment of illnesses that will recur as a result of continuing economic causes.

III. Those of lower income who are able to pay for ordinary medical service but find any serious illness difficult to finance.

This group is normally employed; their living conditions approach that of the average and their contributions to an insurance pool is for the purpose of meeting extraordinary costs due to prolonged illness and disability. The contributions of this group to insurance funds and the hazards of illness among members of the group which will result in demands on those funds are substantially equal. To them insurance offers a useful mechanism for providing for budgeted payments in advance of needs and the equitable distribution of the entire cost. This is the group who have expressed the greatest interest in sickness insurance. Many of them would probably purchase such insurance at once if they were contacted by a dependable insurance company.

This group has in substantial majority expressed opposition to any compulsory Government insurance plan.

IV. This group is made up of those to whom the ordinary incidence of illness does not constitute a hazard of extreme hardship. Those of this group who wish to avail themselves of insurance protection find it possible to do so with private companies and are obviously not in need of Government help.

The American Medical Association has approved of the use of insurance to protect against the hazards of illness but has consistently opposed the establishment of compulsory Government insurance. The reason for this opposition can be briefly stated. The profession is interested in maintaining the highest quality of medical service and it has opposed any proposals that would lead to deterioration

of service. Government-controlled medical service is dependent upon regimentation of the public and the medical profession. The bureaucratic administration which develops as a part of governmental control must inevitably lead to standardization of service at a minimal level. Standardization is never at the level of the superior work, but must always be made low enough to include that of lesser quality. The minimal standard thus tends to become the average level.

Those who advise Government compulsory insurance plans repeatedly use for public appeal the "need for medical care by those who cannot pay for it." Although, as pointed out, the indigent group cannot in fairness to others be included in any insurance plans. However, the proposed Government compulsory plans for prepayment by insurance methods do not permit the individual to use the insurance funds to which he is entitled, to purchase needed medical care. To the contrary, Government possession of the insurance funds is apparently to be used as a means to secure Government control of all the conditions under which the medical service could be provided.

It is an idle statement to say that under such plans the individual could still have his own choice of physician when the conditions of bureaucratic medicine would not be acceptable to a portion of the best physicians and they would not therefore be available to him.

The statement that personal interest and confidential relationship between physician and patient is not important betrays a lamentable lack of understanding of emotional factors and of psychosomatic manifestations of illness and consequently the essential helpfulness of the confidential personal adviser—his physician.

It is not realistic to say that medicine would continue to attract the best minds, if the possibilities for advancement in the profession would have to await the nod of some political bureaucrat, or if opportunity and incentive were stifled in the mechanics of a governmental structure.

It is a distortion of facts to point to the remarkable work of the medical profession of the Army and Navy in war as an evidence that a regimented method for medicine is superior or more desirable. It must be recognized that all but a very few of the medical officers of the armed forces are civilian doctors nearing middle life who are applying their skills acquired in civilian training and experience to the treatment of the unusual exposures and physical and mental wounds of war.

At the conclusion of the war these physicians and patients will return in full agreement that although regimentation is necessary in the Army it is undesirable in civilian life. As a more American, wholesome, self-reliant method of securing protection against the costs of unusual or serious illness for those to whom that protection is desirable, the American Medical Association and its constituent associations are endeavoring to be helpful in securing protection for them through familiar insurance mechanisms. Medical associations have no desire to enter into the insurance business and private insurance companies should find this a desirable field of new business. If private companies are not interested at costs within the capacity of the individuals to pay, mutual and cooperative efforts will no doubt increase. Other methods may be found.

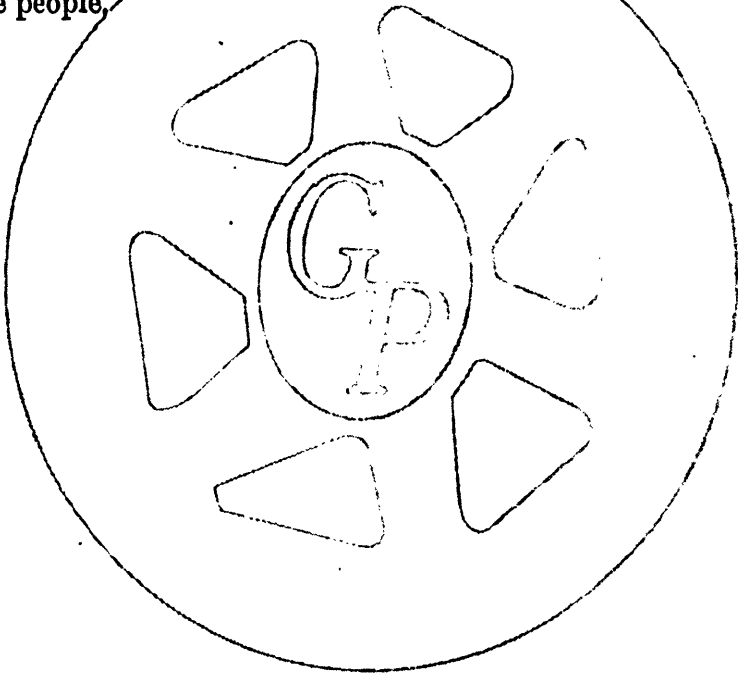


Benjamin Rush, an eminent American physician, signer of the Declaration of Independence, said in 1790 when political independence had been gained and a new form of government had been established upon a basis of principles new to any government, that there still remained to be developed, along those lines, an American economy free from European domination; an American jurisprudence; an American system of medicine; an American orthography; an American plan of education and an American literature.

An American system of medicine of a higher standard than is enjoyed anywhere else in the world has been developed and it continues to progress. The American Medical Association, for nearly a hundred years, has directed its efforts to the improvement of medical service and the broadest distribution of its benefits to the public.

It now becomes necessary to protect the public by opposing the substitution of an un-American system of medicine with bureaucratic regimentation of patients and physicians, such as would destroy those American qualities of medical service that are most important to health and the American way of life.

The American Medical Association will direct its efforts to still further advancement of medical science and will continue to explore every means of making the best possible medical service available to all the people.



### III. STATEMENT BY PHYSICIANS FORUM ENDORSING PRESIDENT TRUMAN'S MESSAGE ON NATIONAL HEALTH INSURANCE

The Physicians Forum strongly approves the message of President Harry S. Truman calling for the establishment of a Nationwide health and medical-care program to supply the medical needs of all Americans regardless of income, race, or religion.

The Physicians Forum is a national organization of doctors, all members of the American Medical Association, who are interested in the extension of good medical care to all the people. In a telegram to the President, Dr. Ernst P. Boas, chairman of the Physicians Forum, said:

Our membership, composed largely of practicing physicians throughout the country who belong to the American Medical Association, most warmly commend you for your able and comprehensive message to the Congress on the state of the Nation's health. You have made a telling presentation of the many unmet medical needs of the country, and have rightly pointed out that the masses of our citizens do not earn enough money to buy adequate medical care.

As practicing physicians we know better than any other group of fellow Americans the difficulties that arise, the needless suffering and death constantly occurring throughout this land because of bad distribution and scarcity of doctors and hospitals in many communities. We know that many regions in this country cannot support the doctors and hospitals they need so badly.

We agree that national health insurance is the only measure that can fill these needs in accord with American tradition; that in addition there must be Federal support for hospital construction, maternal and child-health, extension of public health services, and encouragement of medical research and education. We have learned from experience in this country that voluntary insurance plans are and always will be totally inadequate to serve the health needs of all the people. We, too, regard adequate medical care as a right to which all are entitled.

Early action is needed. Within the coming year tens of thousands of doctors will be returned to civilian life. Now is the right moment to set up such a system of national health insurance which will permit an equitable distribution of doctors throughout the country, before these young men flock to the cities, leaving vast stretches of the country unprotected. As you have so truly stated: "Demobilized doctors cannot be assigned; they must be attracted."

We earnestly hope that the people of the country, through their Congress, will take immediate action to improve these conditions in accordance with your worthy proposal.

THE PHYSICIANS FORUM, INC., FOR THE STUDY OF MEDICAL CARE,  
New York 22, N. Y.

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Rebekah Holland, executive director.

## IV. MEDICAL CARE IN A NATIONAL HEALTH PROGRAM<sup>1</sup>

### A. AN OFFICIAL STATEMENT OF THE AMERICAN PUBLIC HEALTH ASSOCIATION: ADOPTED OCTOBER 4, 1944

At the annual meeting of the committee on administrative practice of the American Public Health Association, October 9, 1943, the committee directed its subcommittee on medical care to draft a set of principles expressing the desirable content of a comprehensive program of medical care, the methods of its administration, and the part which public health agencies should take in its operation. In pursuit of this assignment, the subcommittee completed a tentative draft which was considered and adopted by the committee on administrative practice at its meeting, October 1, 1944. The report was then transmitted to the governing council of the association where, after certain revisions, it was adopted as a statement of association policy.

Because of its composition and charge, the subcommittee has limited its considerations to one sector of a comprehensive national health program, namely, medical care.

In preparing the report, the subcommittee has considered: (*a*) The needs for a national program for medical care; (*b*) the objectives of such a program; (*c*) recommendations for immediate action.

The American Public Health Association, through its national organization and its constituent societies, stands ready to collaborate with the various professional bodies and civic organizations which may be concerned with either the provision or receipt of medical service with a view to implementing the following general principles:

#### A. THE NEEDS

I. A large portion of the population receives insufficient and inadequate medical care, chiefly because persons are unable to pay the costs of services on an individual-payment basis when they are needed, or because the services are not available.

II. There are extensive deficiencies in the physical facilities needed to provide reasonably adequate services. Such facilities include hospitals, health centers and laboratories. The needs are most acute in poor communities, in rural areas, and in urban areas where the population has increased rapidly or where the development of facilities has been haphazard or the financial support inadequate.

III. There are extensive deficiencies in the number and the distribution of personnel needed to provide the services. Here again, the needs vary according to categories of personnel and to characteristics of communities.

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IV. There are extensive deficiencies in the number and categories of personnel qualified to administer facilities and services.

V. Many communities still are not served by public health departments; others inadequately maintain such departments. Thus, some communities have never utilized organized health work to reduce the burden of illness, and others share its benefits only in part. In these communities especially, people lack information on the benefits of modern medical care.

VI. Expansion of scientific research is urgently needed. Despite past and current scientific advances, knowledge as to the prevention, control, or cure of many diseases is lacking.

Each of the six conditions defined above can be broken down into many component parts representing specific needs. In general, however, solutions of these broad problems require simultaneous attack on four fronts: namely, the distribution of costs, construction of facilities, training of personnel, and expansion of knowledge.

#### B. THE OBJECTIVES

I. A national program for medical care should make available to the entire population all essential preventive, diagnostic, and curative services.

II. Such a program should insure that the services provided be of the highest standard, and that they be rendered under conditions satisfactory both to the public and to the professions.

III. Such a program should include the constant evaluation of practices and the extension of scientific knowledge.

#### C. RECOMMENDATIONS

The recommendations presented in this report represent guides to the formulation of a policy for action. It is believed that study of these recommendations by the professions and others concerned in the States and localities will produce new and more specific recommendations for the attainment of the objectives of a national health program.

##### *Recommendation I. The services*

(a) A national plan should aim to provide comprehensive services for all the people in all areas of the country. In light of present-day knowledge, the services should include hospital care, the services of physicians (general practitioners and specialists), supplementary laboratory and diagnostic services, nursing care, essential dental services, and prescribed medicines and appliances. These details of content must remain subject to alteration according to changes in knowledge, practices, and organization of services.

Because of inadequacies in personnel and facilities, this goal cannot be attained at once; but it should be attained within 10 years. At the outset, as many of the services as possible should be provided for the nation as a whole, having regard for resources in personnel and facilities in local areas. The scope of service should then be extended as rapidly as possible, accelerated by provisions to insure the training of needed personnel, and the development of facilities and organization.

(b) It is imperative that the plan include and emphasize the provision of preventive services for the whole population. Such services include maternity and child hygiene, school health services, control of communicable diseases, special provisions for tuberculosis, venereal diseases, and other preventable diseases, laboratory diagnosis, nutrition, health education, vital records, and other accepted functions of public health agencies, which are now provided for a part of the population.

(c) Insofar as may be consistent with the requirements of a national plan, States and communities should have wide latitude in adapting their services and methods of administration to local needs and conditions.

### *Recommendation II. Financing the services*

(a) Services should be adequately and securely financed through social insurance supplemented by general taxation or by general taxation alone. Financing through social insurance alone would result in the exclusion of certain economic groups and might possibly exclude certain occupational segments of the population.

(b) The services should be financed on a Nation-wide basis, in accordance with ability to pay, with Federal and State participation, and under conditions which will permit the Federal Government to equalize the burdens of cost among the States.

### *Recommendation III. Organization and administration of services*

(a) A single responsible agency is a fundamental requisite to effective administration at all levels—Federal, State, and local. The public health agencies—Federal, State, and local—should carry major responsibilities in administering the health services of the future. Because of administrative experience, and accustomed responsibility for a public trust, they are uniquely fitted among public agencies to assume larger responsibilities and to discharge their duties to the public with integrity and skill. The existing public health agencies, as now constituted, may not be ready and may not be suitably constituted and organized, in all cases, to assume all of the administrative tasks implicit in an expanded national health service. Public health officials, however, should be planning to discharge these larger responsibilities, and should be training themselves and their staffs. This preparation should be undertaken now because, when the public comes to consider where administrative responsibilities shall be lodged, it will be influenced in large measure by the readiness for such duties displayed by public health officers and by the initiative they have taken in fitting themselves for the task.

(b) The agency authorized to administer such a program should have the advice and a counsel of a body representing the professions, other sources of services, and the recipients of services.

(c) Private practitioners in each local administrative area should be paid according to the method they prefer—i. e., fee-for-service, capitation, salary, or any combination of these. None of the methods is perfect; but attention is called to the fact that fee-for-service alone is not well adapted to a system of wide coverage.

(d) The principle of free choice should be preserved to the population and the professions.

(e) State departments of health and other health agencies are urged to initiate studies to determine the logical and practical administrative areas for a national medical care plan.

*Recommendation IV. Physical facilities*

(a) Preceding, or accompanying, the development of a plan to finance and administer services, a program should be developed for the construction of needed hospitals, health centers, and related facilities, including modernization and expansion of existing structures. This program should be based on Federal aid to the States and allow for participation by voluntary as well as public agencies, with suitable controls to insure the economical and community-wide use of public funds. The desirability of combining hospital facilities with the housing of physicians' offices, clinics, and health departments should be stressed.

(b) Federal aid to the States should be given on a variable matching basis in accordance with the economic status of each State.

(c) Because of its record of experience and accomplishment in this field, the United States Public Health Service should administer the construction program at the Federal level, in cooperation with the Federal agencies responsible for health services and construction.

(d) Funds available under this program should be granted only if—

(1) The State administrative agency has surveyed the needs of the State for hospitals, health centers, and related facilities, and has drawn up a master plan for the development of the needed facilities (taking account of facilities in adjacent States); or, in the absence of a State plan, the project is consistent with surveys of construction needs made by the United States Public Health Service;

(2) The proposed individual project is consistent with the master plan for the State; its architectural and engineering plans and specifications have been approved by the State agency and/or the United States Public Health Service; and there is reasonable assurance of support and maintenance of the project in accordance with adequate standards.

(e) State health departments are urged to conduct studies to develop State plans for the construction of needed hospitals, health centers, and related facilities. Such studies should be made in cooperation with official health agencies, with State hospital associations, and other groups having special knowledge or interests.

*Recommendation V. Coordination and organization of official health agencies*

(a) The activities of the multiple National, State, and local health agencies should be coordinated with the services provided by a national program. There is no functional or administrative justification for dividing human beings or illnesses into many categories to be dealt with by numerous independent administrations. It is difficult to reorganize agencies or to combine activities, and this cannot be accomplished hurriedly. Therefore studies and conferences should be un-

dertaken without delay at the Federal level, and in those States and communities where the health structure is already unnecessarily complex.

(b) The Federal and State governments should provide increased grants for the extension of adequate public health organization to all areas in all States. Increased Federal grants should be made conditional upon the requirement that public health services of at least a specified minimum content shall be available in all areas of the State.

*Recommendation VI. Training and distribution of service personnel*

(a) Within the resources of the program, financial provisions should be made to assist qualified professional and technical personnel in obtaining postgraduate education and training.

(b) The plan should provide for the study of more effective use of auxiliary personnel (such as dental hygienists, nursing aides, and technicians), and should furnish financial assistance for their training and utilization.

(c) Professional and financial stimuli should be devised to encourage physicians, dentists, nurses, and others to practice in rural areas. Plans to encourage the rational distribution of personnel, especially physicians, should be developed as quickly as possible, in view of the coming demobilization of the armed forces. Such plans should be integrated with the whole scheme of services and the establishment of more adequate physical facilities.

*Recommendation VII. Education and training of administrative personnel*

(a) Education and training of administrative personnel should be encouraged financially and technically, especially for those who may serve as administrators of the medical care program, for hospital and health center administrators, and for nursing supervisors.

(b) State health departments should utilize those funds that may be available to train personnel in such technics as administration of health and medical services, and hospitals. Such a training program may contribute more than any other single activity to the future role of the official public health agency. As a corollary, the attention of schools of public health is directed to the importance of establishing the necessary training courses.

*Recommendation VIII. Expansion of research*

(a) Increased funds should be made available to the United States Public Health Service and to other agencies of government (Federal, State, and local), and for grants-in-aid to nonprofit institutions for basic laboratory and clinical research and for administrative studies and demonstrations designed to improve the quality and lessen the cost of services.

(b) The research agencies and those responsible for making grants-in-aid should be assisted by competent professional advisory bodies to insure the wise and efficient use of public funds.



**B. A BRIEF OF THE REPORT ON MEDICAL CARE IN A NATIONAL HEALTH PROGRAM<sup>1</sup>**

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Before a professional body such as the American Public Health Association, there is little purpose in belaboring the point that the great unsolved problem in public health is one of making available to every American citizen the full benefits of good medical care. The very fact that this problem has already taken on the status of a political issue is a more convincing indication of its importance than any argument or body of statistics that could be adduced. The intemperate support of limited remedial measures by partisan groups, as well as the blind opposition to any change in the status quo encountered from other sources, clearly indicate the need for responsible agencies to give technical direction to the public movement for better medical care. The American Public Health Association should be peculiarly fitted to give such direction, since its members are familiar with the intimate character of medical service and can see the problem from the point of view of both those who receive and those who provide health services.

Mindful of the urgency in this matter, the committee on administrative practice at its meeting in November 1943 directed its subcommittee on medical care to draft a set of principles which would describe the content of a suitable medical care program and methods of administration. Inasmuch as a great wealth of material had already been accumulated through basic studies and as a result of practical experience in the operation of limited medical-care programs, it was decided that the first job for the subcommittee to undertake should be to analyze these findings rather than engage on additional research studies. The subcommittee was fortunate in having as members individuals who had participated in former studies, others who were familiar with the experience gained in various organized methods for distributing medical care, and still others responsible for medical-care programs now in operation—in brief, its composition included both students of the problem and practical administrators.

The subcommittee met several times during the past 12 months. After exploring in detail many of the problems involved in the design of a national medical-care program, the group felt that its thinking had reached the stage at which a statement of principles could be formulated. A preliminary report setting forth these principles has been released. It was published in the September 1944 issue of the *American Journal of Public Health*, with the thought that the entire membership of the association might have ample opportunity to

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study the proposals in advance of formal action. After some modification, this report was accepted by the committee on administrative practice and passed on to the governing council with suggestion that it be considered as an expression of association policy. There follows a brief summary of the report, together with a few of the underlying considerations.

The objective of a national medical-care program should be to make available to the entire population, regardless of the financial means of the individual, the family, or the community, all essential medical services. Such services must be of high standard and rendered under conditions acceptable to the public and the professions concerned. In scope they should include hospital care, the services of physicians, laboratory and diagnostic services, nursing care, essential dental services, and prescribed drugs. Because of inadequacies of personnel and facilities, all of these measures cannot be provided immediately to the whole population, but their complete development within 10 years may be taken as a goal. Regardless of temporary shortcomings, a beginning should be made now in the provision of services to the extent that available personnel, facilities, and administrative techniques make possible. Later, but as rapidly as possible, the program should be expanded to the intended scope.

An achievement of the objectives of a national medical-care program, the subcommittee thought, would require simultaneous attack on five main fronts, namely, distribution of costs, development of administrative organization to provide the service, training of personnel, construction of facilities, and improvement of knowledge.

The basic problem in providing more and better medical care for persons of all circumstances is that of distributing costs over the entire population in proportion to ability to pay. Already the phenomenal success of nonprofit voluntary insurance against hospitalization costs makes it quite apparent that the people desire a convenient way of paying for medical care, and especially a way that will give protection against the risk of heavy bills. Despite such achievements, there is ample reason for believing that voluntary insurance, unaided, will not be able to include the whole population for all of its medical needs.

The subcommittee therefore came to the conclusion that health services must be financed by compulsory social-insurance contributions supplemented by general taxation, or by general taxation alone. Financing through social-insurance contribution alone might result in the exclusion of farmers or self-employed persons, or still other occupational groups, who need the advantages of prepayment as much as industrial and commercial employees. Certain of the long-term disabling conditions, such as mental disorders and tuberculosis, had better be financed for the present at least, as they now are, out of general revenue separate from the provisions for general illness.

The subcommittee was unwilling to compromise the principle that service should be of high quality and available to all persons regardless of economic circumstances or geographic location. It also recognized the desirability of decentralized operation, with participation by State and local authorities. Because of the great mobility of our population and the wide variation in economic resources among the several States and their political subdivisions, an unrelated series of

State or local plans cannot assure a suitable service national in scope. Only the Federal Government, through its broad powers of taxation, can compensate for those differences in income which exist among individuals and among the lesser units of government.

After the fund has been collected, through social insurance or taxation, arrangements must be made whereby the institutions and professions rendering service may be paid for their efforts. The great bulk of service in this country today is performed by voluntary hospitals and private practitioners; they need to be brought into the scheme. Methods of paying hospitals for their services have been developed under extensive voluntary insurance plans; these methods can be readily adapted to the requirements of a national health program. The problem of compensation for professional service is more complex. Inasmuch as fee for service has been a tradition, this, with suitable controls, may have to be accepted as one of the methods; however, the inherent defects in fee for service should be faced, and it should be recognized from the beginning that unsatisfactory experience may in time force more extensive utilization of other methods.

The subcommittee believes that the principle of free choice must be preserved for the public, the professions, and the institutions, namely, that patients shall be at liberty to select their physicians from among all who participate, subject to acceptance by the physicians, and to select their hospitals, subject to the practices and the staff arrangements of the hospitals, and that all qualified physicians and hospitals shall be eligible to participate in the program. This principle should apply to group as well as to individual action.

At the present time public medical-care functions are being discharged through a host of agencies at all levels of government. The effective operation of a national program requires that at each level of government—Federal, State, and local—administration, or the supervision of administration, should be by a single responsible agency. Because of their strategic position in the framework of Government, their record of successful administrative experience, and their interest in prevention as well as cure of disease, health agencies are believed best fitted to discharge the responsibilities incident to administration of a Nation-wide medical-care program. However, any agency that expects to carry major responsibilities in a program of such magnitude and complexity should begin preparing itself now for the position it intends to occupy. When the public comes to consider where administrative responsibilities for a national health service shall be lodged, it will be influenced in large measure by the readiness for such duties displayed by the agency, by the initiative taken in fitting itself for the task, and by the eagerness shown in wanting to accept these responsibilities.

Perhaps of more interest to the members of this association than the operation of a plan at the national level is its management locally. It is here where the program functions in relation to the needs of the people and where the true measure of satisfaction is determined. Irrespective of whether the national program be a Federal scheme or federally aided State schemes, it must operate through units of control that are in direct contact with the people who receive the service, and with the facilities and personnel through which the service is delivered.

The subcommittee gave thought to the proper size of jurisdiction for

local service and to the relative advantages and disadvantages of State administrative districts as compared with districts composed of one or more existing political units. If, as the subcommittee believes, local health agencies should take a prominent part in the administration of medical care, it is difficult to escape the conclusion that material modification in the boundaries of local health jurisdictions must be effected in most, if not all, of the States. For the most part health agencies are built upon a foundation of law enforcement. Consequently, health jurisdictions conform, in the main, to local political boundaries. Many of these areas are too limited in population for efficient administration and their resources are so limited as to make it difficult for them to make any substantial contribution to a program, such as medical care, which involves large sums of money. Furthermore, neither hospitals nor physicians have been accustomed to draw their clientele from within the confines of existing local political subdivisions. In other words, medical service must continue to follow the natural lines of trade areas. Health officers are rapidly coming to the belief that public health jurisdictions also must be reshaped in similar fashion. Whether these areas be made administrative districts of the State, or become new political entities with considerable degree of local autonomy, must be left for determination by the State and local authorities concerned. In reality a decision either way is not of great importance from the standpoint of developing a suitable framework for medical service.

Under an acceptable plan of medical care the hospital must occupy a central position. In addition to providing beds for the more serious cases of illness, its facilities should be generally available for diagnosis and treatment of ambulatory patients and for appraisals of physical status. Before these purposes can be accomplished, it will be necessary to construct additional hospital accommodations in many rural areas where such facilities are nonexistent or wholly inadequate. Even in the larger centers of population a high proportion of present hospitals are in need of extensive alteration, or replacement by more modern structures.

When bringing the total bed capacity of hospitals throughout the country up to actual requirements, a concerted effort should be made to replace the individual and haphazard arrangement that has characterized hospital evolution to date by a planned development under National and State guidance. The scope of service in existing and proposed hospitals should be arranged so as to meet the needs of the localities in which they are situated and fit into both the State and the regional scheme of hospitalization. Under such a plan the modern medical center as well as the outpost first-aid station will have its place.

Closely related to the location of hospitals is the placement of physicians and other medical personnel. A hospital without a competent medical staff is of questionable value, but on the other hand experience has shown repeatedly that a community cannot expect to attract and retain qualified physicians in sufficient numbers unless opportunities for hospital practice are afforded. A large part of the maldistribution of physicians could be corrected in short order if advantage should be taken of the unusual opportunities that will attend demobilization of the armed forces for placing physicians where they are most needed. The presence of hospital facilities, together with the assurance that

funds are available for the payment of medical bills, will go a long way toward effecting a permanent distribution of physicians in proportion to the population. For the more remote and sparsely settled areas some measure of direct aid in addition to the foregoing broad provisions may be necessary. Such instances should not be numerous and neither should the costs entailed be burdensome.

Under an expanded medical-care program shortages of personnel no doubt will be experienced for most categories of service. This is likely to occur especially if the present pattern of practice is carried over into a national program. Dentistry perhaps represents the most critical situation. While this general subject of personnel requirements and methods for meeting probable needs deserves further study, the subcommittee pursued the matter far enough to be impressed with wastages of resources which normally occur. The average physician in private practice does not reach his maximum performance until age 40 and, after a period of about 5 years, a falling off in output begins. The time of nurses consumed in maid and clerical services has been a subject of study and unfavorable comment for years. Now it would appear that many of the operations done by dentists could be assigned to persons of less training than that prescribed for graduation from dental schools. Much more work needs to be done in the way of job analyses before precise statements can be made regarding the extent to which subsidiary personnel can be used to lessen the demands for those in higher educational brackets. Likewise, a great amount of thought needs to be given to the training of auxiliary personnel themselves, and their certification for prescribed types of work. At present this whole matter is in a chaotic state. Until the entire subject of auxiliary workers has been fully explored it will be difficult to make calculations as to the needs for personnel with more extensive preparation.

Of all the groups that contribute to medical service the basic professional education of physicians seems to have been fairly well stabilized at sufficiently high level to assure good quality of medical graduates. If used to full capacity the present number of medical schools, or possibly with moderate increase, should be able to satisfy the normal needs for physicians by the population of the continental United States. The great unsolved problem in medical education is that of keeping physicians abreast of scientific and technical advances subsequent to completion of their formal education. This deficiency is especially apparent among physicians who, because of location or lack of hospital connections, become isolated from their fellow practitioners.

The mere provision of additional hospitals and clinic facilities alone will not solve this problem. A continued educational influence must be infused into the system. This influence should emanate from teaching nuclei which may be located in medical schools or medical centers to which satellite institutions of the surrounding areas are related. In addition, individual physicians must be encouraged to pursue specialized courses so that the particular needs of each locality may be properly satisfied. Within reasonable limits these and other measures necessary for maintaining quality of service should be regarded as appropriate for public support, but should not be charges against the medical-care fund proper.

From the very outset there should be a frank recognition of the fact that any medical-care program is certain to deteriorate unless research goes hand in hand with the provision of service. Hence the support of research, like the support of personnel training, must be accepted as a legitimate and necessary item in the over-all cost of medical care. When selecting topics for basic research, it would seem appropriate that primary consideration be given to conditions such as mental disorders and chronic disabling disease of advancing years, which tend to overburden any comprehensive program of medical care. In the normal course of operating a medical-care program endless opportunities will arise for improving service and reducing costs; such matters constitute appropriate subjects for the administrative type of research. There will also be need for the pilot-plant type of installation in which new procedures are tested and perfected prior to full-scale application.

In the foregoing discussion an attempt has been made to set out the circumstances which prompted the preparation of the report of the Subcommittee on Medical Care, the subject matter considered, and the factors which determined the conclusions. Each of the problems under discussion has many facets. Papers that follow in this symposium represent attempts to describe in more detail the underlying factors which have precipitated out medical care as a national issue, and the corrective measures that seem applicable, together with appropriate methods of administration.

## **V. PRINCIPLES OF A NATION-WIDE HEALTH PROGRAM**

This report, by its 29 sponsors, is published with the cooperation of the Committee on Research in Medical Economics. Through the committee, arrangements were made for the meetings of the conference and of subcommittees, in the autumn of 1943 and in 1944.

The expenses of the conference and of this publication were met by gifts contributed for this purpose. The sponsors acknowledge with appreciation the generosity of these donors.

### **FOREWORD**

#### **AIM AND SPONSORSHIP OF THIS REPORT**

The purpose of this conference is to formulate the elements of a Nation-wide health program which would unite the views of physicians, economists, and administrators. The composition of the conference indicates both the diversity and the unity of the participants. All agree that good medical care is a necessity of life, comfort, and efficiency; that the need for medical care is now insufficiently met for large numbers of persons; and that, to meet the need, public action is required on a Nation-wide scale, as well as action by voluntary organizations and by individuals in their own behalf. All therefore agree in anticipating and welcoming important changes in the organization of medical services and in methods of paying for them.

This report has been worked out by meetings of our whole group, by subgroups, and by correspondence. Each person has participated in the conference as an individual and approves this report as such, not as a representative of any agency. At a few points in the report alternatives are presented, representing the views of one or more members, as indicated in the text.

We appreciate the important roles of dentistry, nursing, and pharmacy, but have been compelled to restrict our scope to physicians' and hospital services. Even within this range the conference could deal only with selected subjects in the limited time available.

## REPORT OF THE HEALTH PROGRAM CONFERENCE

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### I. ISSUES AND PRINCIPLES OF A NATION-WIDE HEALTH PROGRAM (SUMMARY)

American medicine at its best is unsurpassed, but it is also beyond doubt that the medical facilities and services actually available to many of our people are far below the best or even the sufficient. There have been great achievements of the American medical profession, American hospitals, public health and welfare agencies in providing care for sickness, educating personnel, advancing medical knowledge, reducing and preventing disease. Nevertheless unmet needs for medical care are widespread and the burdens of sickness costs are heavy and sometimes overwhelming. There has been a gratifying reduction in the death rate, but the lowering of death rates is not an adequate measure of the extent to which medical care is available or needed. Moreover, the fact that death and disease rates are much greater in some States than in others, and greater among low- than among high-income groups, demonstrates that there are still unmet needs and opportunities.

Medical services should be made financially accessible to all through a national system of contributory health insurance, combined with taxation in behalf of people without sufficient income, preventive services and needed extensions and improvements of facilities. In order that comprehensive service shall be available to all or most of the population and in order to minimize the administrative costs of acquiring members, it is essential that financial participation in the system be required by law. The contribution for medical-care insurance will not mean an added burden on the earnings of workers. The American people are now spending for physicians' services and hospitalization enough to provide for all with only minor supplementation, if these payments are regularized, instead of falling with disastrous uncertainty. Place should be maintained for voluntary action by many agencies as well as for action by our National, State, and local governments.

To achieve this financing would be a boon to millions; but financing alone will not guarantee satisfactory medical service. The amount and economy of medical care are greatly affected by the methods through which the services are organized and paid for; by the geographical availability of hospitals, physicians, and other personnel; by the provisions for professional education, and by the opportunities



for the pursuit and application of science. The same factors also largely determine the quality of care. A health program must coordinate both professional and financial ends. With the growth in the powers of medicine to prevent and control disease, a program dealing mainly with serious or "catastrophic" illness is insufficient medically and uneconomical financially. The program will be most beneficial and economical if it includes measures for prevention, for the detection and care of illness in its early stages, and for rehabilitation.<sup>1</sup>

The people and their physicians must be assured freedom in service, the right to act through self-chosen organizations as well as individually, and the opportunity for free experimentation with new applications of science and new forms of medical practice.

In emphasizing the necessity of adequate compensation for physicians and hospitals, we have suggested principles for judging adequacy. Greater economic security should not reduce professional competition among physicians. It should discourage competition which is merely financial, with its attendant evils.

The people will be assisted in selecting their physicians and other resources for care, and physicians will be enabled to supply the best service, if services are supplied through teamwork in organized professional groups and with hospitals as the centers from which most preventive and curative services radiate. A Nation-wide health program should expedite the present evolution of American hospitals in this direction, by providing financial underpinning and stimuli to improved hospital organization.

The program presented in this report rests upon 10 principles:

1. Comprehensive coverage and service.
2. Spreading of costs.
3. Distribution of facilities according to community health requirements.
4. Encouragement of group medical practice with hospitals as professional service centers.
5. Determining policy through participation of those who receive and of those who furnish service.
6. Responsibility of the professions for strictly medical activities.
7. Freedom for physicians and patients.
8. Adequate payment of physicians and hospitals by methods which encourage quality and promote economy of service.
9. A national system.
10. Local administration of services under national standards.

The physicians, the hospitals, and the public of each locality must deal with the ultimate distribution of medical care, under general standards which make place for voluntary as well as governmental action, and which give room for freedom and supply helpful incentives.

In proceeding toward a health program that will serve millions with comprehensive, scientific medicine, the interests of both the people and the professions should be integrated in the planning, and both public and professional groups must participate throughout. Their interests are opposed only when, through separation,

<sup>1</sup> These and other related principles are developed in the noteworthy Report on Medical Care in a National Health Program, adopted in October 1944 by the American Public Health Association and published in the December 1944 issue of its journal.

they fail to appreciate their mutual dependence. The people cannot obtain a high quality of service unless adequate training, intellectual freedom, and economic security are assured their physicians. The medical profession cannot realize the highest social esteem nor its traditional ideal of service to all according to their needs, unless the financial accessibility of service is assured the people. The elements of service, science, efficiency, and economy are intermingled and interdependent. They cannot be pursued separately without lessening effectiveness and creating tensions. The health program presented here arises from the belief that there is now need for public action to make adequate medical care more widely accessible to the American people and to improve the quality, organization, and economy of medical services.

## II. PARTICIPATION IN A NATION-WIDE HEALTH PROGRAM

Those who receive medical services comprise all of us. A few major organized groups represent many of us—employers, labor, farmers. Churches, women's organizations, academic, fraternal, and welfare bodies—one classification crosscutting the other—represent other important elements in the consumer group. All such groups have a common concern with the availability, efficiency, and economy of medical services. The medical needs and ways of meeting them differ, however, among population groups—between rural and urban sections, for example. Employers are concerned with medical services as consumers, but also have other special responsibilities as employers. These diverse and yet allied interests need representation in planning and administering a program.

As compared with the 135,000,000 people who need service, those who supply service number only a million or so, but these also include diverse elements—physicians, hospital and public-health administrators, dentists, nurses, pharmacists, and other professions and vocations as well as the numerous specialties within medicine.

Considering physicians alone, service today depends not only upon the individual doctor, whether general practitioner or specialist, but also upon other important groups and agencies, such as the organized faculties of medical schools, laboratories, research institutions, public health and public welfare bodies, and the administrators and trustees of hospitals. In planning and providing medical services, these functional groups need to have direct participation, along with the medical societies which represent mainly the physicians in private practice. Only thus can there be included all the elements which are essential to provide needed services, maintain quality, and advance standards.

## III. OBJECTIVES OF A NATION-WIDE HEALTH PROGRAM

*General aim.*—Good medical care—preventive, diagnostic, and curative—should be available to all the people in proportion to their need for it, and regardless of their ability to pay.

*Scope of care.*—“The health service of the future should be comprehensive and coordinated, embracing community health and individual health, prevention, and cure.”

Plans of medical care which are limited to hospitalization, surgery, or catastrophic illness only, do not express the ideals

of medicine, nor do they apply the present powers of medicine at the most effective points or in the most economical ways. Plans which provide cash payments only, to meet the cost of some services in whole or part, are still more limited in medical and economic value. Only comprehensive preventive, diagnostic, and curative service will minimize disability, inefficiency, and premature death, which bring heavy losses to individuals and to the productivity of industry and agriculture.

*Quality of care.*—Legislation and administration should be designed to maintain, promote, and extend a high quality of medical care, especially in those areas and those kinds of medical service which at present need improvement.

*Relation to maintenance of income.*—A health program should be associated with a broad system of social security which, through insurance and other measures, assures at least a minimum income for ordinary family expenses during periods of unemployment, disability, and maternity, dependency due to the death of the bread winner and throughout old age.

Medical services differ from the other branches of social security in several important ways. They involve the provision of services, not merely cash payments. American families ordinarily spend directly about 4 percent of their earnings for all kinds of medical services. Of this, the expenditures for physicians and for hospital services constitute about three-fourths, i. e., about 3 percent of annual income. The percentages are larger among low-income groups. The insurance principle applied to medical expenditures means regularizing existing payments rather than imposing new burdens.

*Relation to housing, food supply, employment, and education.*—The health of body and mind is interdependent with the conditions of home life, occupation, and nutrition. The best medical care may be futile if the individual lives or works under bad conditions, or if, because of poverty or ignorance, his food is insufficient or ill-balanced. Nevertheless, competent medical services can remove many hazards and disabilities and can directly aid the individual to improve his income and living conditions. A health program need not and should not wait for general economic reforms, nor could its purposes be accomplished through such reforms alone. It will be assisted, and should be accompanied, by a high level of general education and by increased attention to education in health matters.

*Facilities.*—At the present time, physicians and hospitals are insufficient in certain areas and were so before the war. The same is true of local public health departments supplying sanitary and preventive services. If the economic barriers to medical care were largely removed from individuals through health insurance and taxation, the demand for medical services and hospitalization would increase, so that physicians and hospitals might be insufficient even in areas where previously they could meet local demands. A Nation-wide health program must therefore include provisions whereby medical facilities—such as hospitals and health centers—and personnel—such as physicians, nurses, and technicians—shall be made available physically as well as financially in all sections of the country.

*Costs.*—When the costs of medical care are paid for by people as sickness occurs, according to the traditional system of fees to physicians and hospitals, these costs fall unevenly and unpredictably upon individual families. Such costs cannot be regularized in the family budget as can other items of expenditure, and they consequently bring financial distress and sometimes economic disaster to many families of all income groups except the well to do. Furthermore, the cost or the fear of cost often lowers the adequacy of service, or prevents the utilization of services at a time when they would do the most good.

Appreciation of these facts has become common among the general public and among the professions, and it is now widely accepted that the costs of medical care should be distributed among groups of people and over a period of time.

One method of thus distributing medical costs is through insurance. Another method is through taxation. These methods may be utilized separately or in combination. Both of them are employed today in this country, but to a limited degree, and mostly for special types of care or for particular groups of the population.

*Services.*—These methods of paying for care can assure people of the financial accessibility of services, but cannot of themselves insure that efficient and adequate services will actually be supplied. The quality and the amount of service are greatly influenced by six factors: (1) The training and skill of the physicians and other professional personnel, (2) the material facilities and equipment, (3) the geographic accessibility of professional personnel and facilities, (4) the attitudes of the people toward health care, (5) the manner in which medical services are paid for, and (6) the way in which they are organized.

*Group medical practice.*—The last-named factor needs especial attention. At the present time, most medical care outside of hospitals and clinics is supplied by physicians who practice as individuals, with limited equipment and facilities. The advance of medical knowledge, however, makes it no longer possible for any one physician to master more than a fraction of medical science or of professional skills. Moreover, modern facilities and equipment have become too extensive and too costly for individual physicians to provide for themselves.

For these reasons, the best medical care requires coordinated instead of individual practice. An organized group of doctors, including general physicians and specialists in due proportions, with pooled use of equipment and assistant personnel and in affiliation with a hospital, represents the most desirable form of service. There are sufficient examples of group practice in the United States to demonstrate its efficiency and economy. Numerous studies have shown that, through well-organized group practice under a prepayment plan, about twice as much physicians' and auxiliary service may be furnished for the same total expenditures as the people are accustomed to spend for comparable services supplied in the same community through individual practice paid for on a fee-for-service basis. These studies also indicate that (1) economy in the cost of service is possible in group practice because of the more effective use of personnel and facilities, and reduction in overhead expenses; (2) the quality of care furnished by a well-organized group of physicians is usually better than, and certainly at least as good as, that furnished by individual practitioners

serving similar population groups in the same community; and (3) these advantages to the public are accompanied by improved professional opportunities and more assured income for the physicians.

*Specific aims.*—A Nation-wide health program should therefore seek to accomplish four main results: (1) Comprehensive medical services and facilities shall be physically and financially available to all the people; (2) these services shall be so organized and supplied as to be scientifically efficient, and as economical in cost as is consistent with quality; (3) the services shall be adequately and securely financed; and (4) professional opportunities shall be improved, and adequate income assured the persons and institutions furnishing service.

Thus the medical aims and the economic aims must be brought together.

#### IV. GENERAL OUTLINE OF PROGRAM

*National action.*—The health program should be a national system, with decentralized administration of services. National action is required for a number of reasons; e. g.—

(1) We have a mobile population. There should be equal eligibility for medical service everywhere, for persons moving from one State to another.

(2) At present there are great divergences in the relative wealth of different areas, and in the services and facilities available among the different States and among local areas within States. Many of the localities now most poorly provided for, or lowest in purchasing power, are those which, through a large excess of births over deaths, are contributing most of the Nation's future population. The whole Nation is therefore concerned with reducing the existing geographical inequalities in medical facilities and services.

(3) Economies can be achieved through a unified national collection of funds.

(4) Past experience shows that standards of medical and hospital care established nationally by governmental and voluntary agencies are effective in raising the level of facilities and services in many localities, while maintaining local responsibility.

(5) There need to be national standards, for example, for the certification of specialists, the acceptability of hospitals, the amounts and methods of payment to hospitals and physicians, the conditions of service, and the adjustment of complaints. But these standards and policies must be adaptable to local conditions and their ultimate application demands responsible local action.

*Relation of States.*—A national health program may be administered on a Federal or a Federal-State basis.

*Policy.*—The determination of policy, on national, local, and intermediate levels, should be by bodies representing the public interest.

*Local responsibilities.*—There should be responsible participation of local people, physicians, and agencies (governmental and volun-

tary) in the administration and control of their health services, under national standards. Medical care cannot be run satisfactorily by remote control.

The policies of administrative decentralization and of local participation should be clearly expressed in legislation.

*Functional local areas.*—The services of many hospitals and specialists extend over areas the size of which depends on the number, density, and economic status of the population, and upon the facilities for transportation. Functional local areas frequently cross the boundaries of cities, counties, and often State lines also. Medical and hospital services can be administered most effectively if they can be planned in such functional local areas. The powers, funds, and administrative agencies of local political subdivisions, and of the States, must be utilized in planning and in the provision of services.

*Voluntary action.*—Voluntary agencies, with their extensive facilities, should be utilized as well as governmental agencies.

*Coverage.*—At least nine-tenths of our population need protection against the uneven and unpredictable costs of sickness. Most of our population need access to better organized professional services. Limitation of coverage to certain income groups or to those engaged in certain occupations is not desirable. However, those who wish to purchase medical care outside of the national health system should be free to do so.

Three members of the conference believe that it would be wise to permit a maximum development of voluntary health insurance for families of the middle economic levels. They would therefore favor the immediate application of contributory health insurance under a national system only to persons with annual earnings below some fixed figure, somewhere between \$2,000 and \$3,000.

Five members who accept broad coverage as the goal think that it should be attained gradually to avoid lowering the quality of care.

It is, however, feasible and desirable to start with broad coverage. The services available will be at least as good in each area as those to which the population of that area has been accustomed. Furthermore, broad coverage would stimulate the improvement of facilities and personnel, and therefore of the quality of care.

A national health program should therefore include, in its coverage, all or most of the population. If the health program is established as part of a general system of social security, this system should include all insured employed and self-employed persons and their families, and indigent and other persons who, because of employment or income status, are not directly eligible to the insurance system.

Among such persons are those who are legally dependent on State or local governments, or who receive federally supported assistance, or who for other reasons are ineligible for social insurance benefits when they require medical care. Such persons should as far as possible obtain medical services from the same sources and under the same conditions as beneficiaries of the insurance system. Payment should be made in behalf of these persons by the local, State, or national agencies responsible for them.

There is at present a tendency for a double system of medical care to develop (1) a poor-man's system supported by taxation, under welfare departments and other governmental auspices, and restricted to indigent and other needy persons; (2) an insurance system for employed persons and their families, supported by payments from them and sometimes from their employers also.

The second group is potentially very much the larger. Medical efficiency and economy and general social considerations are against a double and in favor of a unified system.

*Finances.*—The chief support of a Nation-wide system of medical care should be contributory insurance required by law, with the amounts of payment from employees, employers, and self-employed persons related to the earnings of the contributors, combined with support from general taxation.

It is considered by some that general taxation provides a more flexible and theoretically more desirable method of distributing the costs of medical care among large groups of people and over a period of time. An income tax earmarked for medical purposes has been suggested. As a practical program, however, primary use of the contributory principle is recommended for financial and other reasons.

One member wishes to emphasize his belief that the insurance method is for those employed and self-supporting, and the taxation method for those who are not employed and who need assistance.

As stated previously, the insurance principle, applied to medical costs involves the utilization and organization of expenditures to which the people are already accustomed. Furthermore, the contributory principle makes service a right and dissociates it from the onus of charity. If the Nation-wide health program is associated with the other branches of social security, coverage for the medical services can be made identical with, or broader than, coverage for old-age and survivors insurance, with no additional machinery or expense required.

We agree with the recent statement of the International Labour Office, that medical care should be "provided without qualifying conditions as to payment of contributions or taxes and without means test." Tax-supported medical care, however, is associated with dependency in the minds of most people in this country. The extension of tax-supported medical care would have to proceed gradually for financial and political reasons, and would be likely to proceed from dependent and low-income groups upward, and to be held back at each stage by demands from sections of the public and of the medical profession for an income limit and a means test. Broad coverage can be more effectively maintained through the contributory principle.

A supplemental proposal, retaining this principle is to draw a substantial part of the total cost from general taxation. From the expenditures of the American people for medical care referred to on page 6, it is evident that a required contribution of 3 percent of earnings from employed or self-employed persons would be no addition to their present direct burdens. If the required

contribution from employed persons were lowered because of contributions required from employers, there would be a corresponding lessening of the burden.

Eliminating all or part of the contributions from employers and employees and utilizing taxation instead would require an increase in income or other taxes. The ultimate incidence of the burden, when contributions are levied directly upon employers, and the relative advantages and disadvantages of various combinations of the contributory and general tax principles, are matters for fiscal and political experts rather than for those primarily interested in medical services.

*The place of general taxation.*—The national health program should include general tax funds from the start, especially to aid (a) new or improved hospitals and health centers, particularly in rural areas; (b) the further extension of full-time public health departments and other preventive measures, so that every part of the country will be served thereby; and (c) the provision or improvement of medical services to those dependent and other persons not directly covered by the insurance system. The chronically ill, the disabled, and the aged are important sections of this group.

General tax funds now support such medical services as—

(a) Complete preventive and curative service to the armed forces, from Federal funds.

(b) Hospital and other medical care for veterans, from Federal funds.

(c) General medical and hospital care for dependent persons, mostly through State and local governments, with Federal funds for certain groups.

(d) Specialized care, largely in institutions, for persons with mental diseases, tuberculosis, and a few other diseases; supported by State, Federal, and local governments in that order of importance.

(e) Preventive services, mainly for certain diseases and conditions of public health interest; mostly through State and local governments, with substantial Federal participation under titles V and VI<sup>2</sup> of the Social Security Act and under other laws.

A total of some three-quarters of a billion dollars annually was expended from tax funds in the prewar period for these purposes. This was nearly one-third of the total expenditure for all physicians' and hospital services in the United States.

These public services and expenditures should be related with those of a national health program, so as to tend toward a professionally unified and financially economical system; and the whole program itself should be closely related to existing National, State, and local public health services.

*National collection of funds.*—The finances of the system should be national; i. e., the contributions from individuals and employers should be levied and collected by the Federal Government.

National collection of funds is especially advantageous when the health fund is collected along with other social-security pay-

<sup>2</sup>Title VI of the Social Security Act was repealed by the Public Health Service Act of 1944 but was incorporated into this new act (78th Cong., Public Law 410, sec. 611).



ments. Thus a single combined payment becomes possible, with great saving in record keeping and other administrative work.

National collection of funds is compatible with any one of the several possible systems of disbursing the funds and administering the services, whether a direct Federal system, a Federal-States system, a Federal-local system, or variants of these.

*Capital funds for facilities.*—The establishment, enlargement, and improvement of hospitals and health centers require capital funds which, insofar as unavailable from nongovernmental sources should be provided by Federal, State, or local taxation, or combinations of these.

*Rural needs.*—The primary need for rural areas, as for urban, is, of course, broad coverage of the population by the social security program to provide for the payment of all medical and related services. With the adoption of this basic measure, many subsidiary problems would be on their way to solution. Many rural needs, however, cannot be met simply by providing means of paying the current costs of medical services. Such a system would assist in maintaining rural physicians and hospitals, and would tend to attract more physicians; but there are many rural areas wherein the physicians and the hospitals requisite for adequate or even minimal service do not exist. In general, moreover, the quality of medical service is inferior in many rural areas.

Shortage of physicians existed in many areas before the war, and was increasing. Relatively few young physicians have been locating in rural areas. There has been an increasing preponderance of physicians in the older age groups, men far removed from scientific medicine and its current developments. The war has enhanced the shortage of rural physicians. It is questionable how many of those drawn from rural areas into the armed forces will return to rural sections after demobilization, unless opportunities for rural practice are improved. Basic public health services are also deficient or practically absent in many rural sections.

The accentuation of rural medical problems by the war renders it especially desirable to plan ahead to meet rural needs when the war is over. At that time hospitals can again be constructed, enlarged, or improved, and some 60,000 or more physicians will be demobilized, about 20,000 of whom will be young men who have never been in practice.

Therefore, a Nation-wide health program, planned now, should give especial attention to the needs of rural areas in the following ways:

- (1) It should recognize that without good local diagnostic and hospital facilities and greater assurance of adequate income, the long-time trend of young physicians away from rural areas cannot be altered after the war.

- (2) It should provide capital funds for the construction of needed hospitals and health and diagnostic centers, and for the enlargement and improvement of existing institutions; with emphasis on the development of the rural health center or combined health center and hospital as a place to house the health department and to provide offices for local physicians as well as furnish needed diagnostic and therapeutic equipment.

(3) It should promote organized arrangements among hospitals and public health and other agencies whereby laboratory facilities and the services of specialists can be made available to the people and the physicians of communities too small to maintain such services for themselves, with organized provision for the referral of difficult cases to larger centers.

(4) It should encourage the local organization of rural people, along with their physicians, for the purpose of promoting the development of health services adequate to meet their particular needs as part of a Nation-wide program.

(5) It should further the extension of public health services and their coordination with curative services, and should stimulate the passage of mandatory State legislation for full-time health departments organized on the basis of districts with population and area optimal for efficient administration. There should be emphasis on coordinating public health and medical care administration in rural areas, or, where practicable, integrating them.

(6) It should establish effective national machinery for aiding in the post-war relocation of physicians.

(7) It should promote (a) the development of medical education along lines designed to increase the number of physicians going into rural practice and (b) opportunities for institutional graduate study by rural physicians and also for "graduate study in place," assisted by periodic visits to rural communities by consultants, demonstrators, and lecturers from medical teaching centers and State health departments.

#### V. PRINCIPLES OF FREEDOM

*Freedom.*—The general principles of freedom for people in the choice and change of medical resources, and the corresponding freedom for physicians to accept or reject patients, are basic protections against regimentation, and should be extended beyond what exists today.

With the increased complexity of medical services, the variety of specialists, the extension of hospitals and other organized agencies providing care, the choice of resources for medical service has become far from simple. Increasing numbers of patients choose their physicians by selecting a hospital, clinic, or other organized agency, having confidence that any member of its professional staff will be competent. There is at present little or no free choice of physicians and hospitals by many patients, especially those who have small means and those who live in small towns and rural areas.

A publicly established system of medical care should recognize the right of choice among the variety of resources accepted by law or custom; and the right of the people to information regarding all such resources.

*Range of choice.*—Beneficiaries of a publicly established plan of medical care should be entitled to choice among individual physicians, organized groups of physicians, hospitals, clinics, and any other agents or agencies of service recognized under the law; and to change their sources of service when they so desire, under reasonable regulations.

*Group choice.*—The choice among physicians and hospitals to render service to the members of an organized group of beneficiaries may be made by representatives chosen by these members.

*Professional freedoms.*—Physicians should have the right to accept or reject patients; the right to participate or not to participate in a publicly established system; the right to be represented in negotiations through organizations of their own choosing; and the right to furnish services as individuals, or to organize medical groups, or to associate themselves with existing medical groups or hospitals which will accept them.

*Public information.*—Information furnished by public authorities concerning the available sources of service in any area should include all participating agencies and individual practitioners.

Under a publicly established plan of medical care or hospitalization, lists of all the participating practitioners, hospitals, clinics, private medical groups, and other agencies through which services may be obtained under the law should be available to the people of the area.

*Voluntary agencies.*—Voluntary agencies providing services of acceptable standard should have the right to participate in the system. Voluntary agencies not providing services should have the right to participate if they would contribute to the efficiency and economy of the system.

Under these principles, voluntary agencies which directly provide physicians' services or hospitalization of acceptable standards would be eligible to participate in the system, but agencies would not necessarily be included when they were concerned only with the collection of funds and the distribution of cash indemnities to beneficiaries.

Under these principles, voluntary hospitals would remain as independent agencies which would make individual or group contracts for furnishing services under the national program and which would retain full responsibility for their own administration.

Some existing voluntary agencies, like the Blue Cross hospitalization plans, do not actually furnish services, but they do organize and administer a system through which services are provided and they pay for the services in behalf of the beneficiaries. Such voluntary agencies might be recognized as administrative agents of a public system in certain areas, when such recognition would contribute to the efficiency and economy of the whole system within that area.

Voluntary agencies might function along with a publicly established system by assuring supplementary services or financial protection beyond what is supplied by the public system; e. g., the extra expenses of semiprivate or private accommodations in hospitals. Voluntary agencies furnishing such supplementary insurance might also participate in the public system under the preceding principles, and would then receive and administer, on behalf of their service agencies, both the public and the supplementary funds, provided that such participation contributed to the efficiency or economy of the system as a whole within the area covered.

## VI. MAINTAINING AND IMPROVING THE QUALITY OF MEDICAL CARE

*General policies.*—The quality and the continued improvement of medical services cannot be assured unless there is ample support for medical education and research; freedom of experimentation in medical science, medical technology, and in the forms of medical practice; and unless the career of a physician offers stimulating professional opportunities and adequate financial compensation.

The national program should therefore—

(a) Aid in the improvement of professional education and in the advancement of knowledge concerning the causes, prevention, and treatment of disease;

(b) Provide for the establishment and observance of standards for hospitals that may supply services under the law;

(c) Provide for the establishment of standards for the certification of physicians who may be designated and compensated as specialists under the law;

(d) Utilize methods of administration, including methods of payment to physicians, which will encourage the provision of adequate personal service with the greatest economy; and

(e) Provide standards and opportunities for the training of administrative personnel.

*Methods of paying physicians.*—For compensating physicians, the following principles should be observed:

1. Compensation should be adequate.
2. Adequacy should be estimated in terms of annual income.
3. In judging adequacy of income for any physician or section of physicians, consideration should be given, among other factors, to the professional incomes usual among physicians of comparable ages, specialties, and types of community.
4. Compensation should be commensurate with skill, experience, and responsibility.
5. The methods of payment should be such as will maintain professional competition and discourage financial competition among physicians.
6. Compensation should, wherever possible, be on a basis not directly related to the amount of service supplied to any individual patient.
7. Having regard to these principles, a national plan of medical care should recognize three methods of payment, or combinations of these: salary, capitation, and (under certain conditions) fee for service.

Of the existing ways by which physicians are compensated, the fee-for-service method, of course, preponderates. Full-time salaried physicians caring for patients (excluding those performing administrative work only) numbered probably about 10 percent of the physicians in the United States just before the war. A larger number was on part-time salary. Specialists in clinic service are often paid on a session basis; i. e., an agreed sum per clinic of a specified number of hours.

Under the capitation method, the physician is paid a fixed amount per annum for each person who selects the physician as his regular doctor. The amount of remuneration of each phy-

sician thus depends on the number of persons choosing him, but is independent of the amount of work he does for them. The capitation method is readily applicable to the remuneration of general practitioners, but would rarely be suitable for the compensation of specialists. It requires much less administrative work than the fee-for-service method. It provides an economic incentive to the physician to satisfy his patients and to keep them well.

The fee-for-service method is most open to abuse by patients and physicians and is the most costly to administer. Adequate control of the services requires fiscal and professional supervision, which is expensive and often vexatious. The promotion of quality and of prevention is difficult. The use of the fee-for-service method should therefore be discouraged, except for specialist services under certain conditions.

The principles stated for judging adequacy of income (Nos. 2, 3, and 4) make possible the use of any one of the three methods of payment, or of combinations of them. They also provide a basis on which local adjustments of compensation can be fairly made. The methods of payment used greatly affect the quality of service and the expense of administration.

Principles No. 5 and No. 6 taken together would tend to encourage the compensation of general practitioners by the capitation or the salary method; but, as stated in the following paragraphs, there would be local determination by the individual practitioners of the method of payment which they preferred, while those physicians who wished to carry on group instead of individual practice in the same area and to be remunerated accordingly, would also be protected in their right to do so.

*Local adaptations.*—The methods and rates of payment to physicians cannot be uniform throughout the country but must vary according to local conditions and with the nature of the services. In any area, the methods of remunerating physicians may be determined as follows:

(a) For general or specialist services provided by organized staffs of medical agencies such as hospitals or clinics: Each such staff, in agreement with the authorities of its agency, would determine the method or methods whereby its members would be remunerated.

(b) For general medical service provided by individual practitioners: All such practitioners of the area would determine the method of their remuneration by majority vote.

(c) For specialist services provided by individual practitioners: The method would be determined by majority vote of all the practitioners of each specialty in the area.

With respect to paragraphs (b) and (c), further study should be given to possible methods of permitting the supplementary use of a method of payment for the minority, other than that determined by majority vote.

*Specialists.*—Physicians qualified to furnish specialist or consultant services under a system of medical care, and to be remunerated accordingly, should be designated by professional bodies under national standards regionally and locally administered.

Such standards should have regard to the professional education of the physician, to his special experience, and to the conditions in the type of area wherein his services would be utilized.

If standards for specialists and consultants are based only upon uniform national specifications for the professional training and experience of the physicians, many of the less densely populated sections of the country would have no recognized specialists at all. The specialists certified by the professional specialty boards are located preponderantly in large cities and medical teaching centers. Many whole States have only a few physicians thus certified in important specialties, and there are large areas in many States which have no certified specialists at all. These sections are now served by physicians who practice full or part time in a specialty, although they do not qualify for certification by a specialty board. In most instances these physicians are accepted as specialists by one or more approved hospitals in their locality.

While the outlook is that the requirements of the specialty boards will be more and more widely met in the future, nevertheless for some time to come, in many communities, the local conditions of medical and hospital practice must be considered, as well as the specialty-board requirements, in certifying specialists and consultants for service in a plan of medical care covering all or most of the population.

Well-organized hospital staffs currently serve to certify the competence of individual physicians on those staffs for performing certain functions; e. g., major surgery, pathology, ophthalmology. Hospital staffs now serve this purpose locally, supplementing the national specialty boards. Hospital staffs act thus under the legal governing body of the hospital, usually a lay board of trustees. The powers of such hospital boards would continue to exist and to be exercised under a national system.

In some sparsely populated areas, specialist and consultant services can be supplied only by qualified physicians visiting the locality at intervals, according to a plan covering a number of localities or a whole State.

#### VII. GROUP MEDICAL PRACTICE

Group practice, previously mentioned, has been defined as follows:

Group medical practice is the application of medical service by a number of physicians working in systematic association, with joint use of equipment and technical personnel and with centralized administrative and financial organization.<sup>3</sup>

Group medical practice is found today in conjunction with all of the forms of payment for medical care. Thus, persons receiving attention from most private group clinics and from some salaried hospital staffs pay fees. Some private groups and some hospital staffs serve persons who pay for their medical care under an insurance plan. Both private and hospital groups care for some

<sup>3</sup>In a report by a committee of eight physicians (of whom five are members of this conference); published in 1940 by the Committee on Research in Medical Economics.

persons whose medical expenses are paid by philanthropy or by taxation.

In many of our best hospitals and their out-patient departments, the professional staff conducts well-organized group practice for nonpaying patients, and supplies these patients with both general and specialist care, and diagnostic service, but home care is rarely included. Group medical practice in the private clinics, when organized primarily for the purpose of caring for patients referred by other physicians, does not furnish general medical care. Many private groups do so, however.

A Nation-wide health program should encourage group medical practice—

(1) by making both physicians and patients free to initiate or to participate in it.

All young physicians now receive their education under conditions of group practice in hospitals and clinics, and should be encouraged to understand its advantages as a career. The public should appreciate that properly conducted group practice means a high quality of personal attention supplied with maximum economy, not an impersonal service.

(2) By adhering to the general policy that medical service, when paid for under the system, shall be supplied at the lowest cost consistent with a high quality of care.

(3) By use of hospitals as medical service centers.

The organized staffs of the best hospitals and clinics now constitute the most widely diffused examples of group medical practice. The full advantages of such service are at present chiefly confined to nonpaying patients. Similar benefits should be available to people of all income groups and should be extended to include home care.

#### VIII. HOSPITALS

*Medical service centers.*—The national program should encourage a policy under which hospitals would function as medical service centers, offering preventive, diagnostic, and treatment services for bed, ambulatory, and home patients and providing office facilities for the physicians on their staffs.

The typical general hospital in the United States now provides quarters, equipment, and an organization of professional and technical personnel which furnishes a better basis for medical service than can be had by any physician or small partnership of physicians working alone.

There are examples of hospitals which are medical service centers now. Their medical staffs provide diagnosis and treatment for ambulatory ("office") patients within the building, as well as for bed patients; and within a certain distance will supply care in the homes when this is necessary.

Hospitals can advance in the direction of becoming medical service centers by gradual steps. A number of leading hospitals have, for example, supplied space within their buildings or in an adjoining building, for the office or "clinic" practice of their staff physicians.

The organization of the typical nonprofit American hospital is under a lay board of trustees. This board appoints the professional staff, and this staff is organized under authority granted by the board, so as to be self-determining in all purely professional matters.

Hospitals acting as medical service centers would be encouraged under a national health program by the measures which follow, and by several of those which have been already stated, especially (1) assuring the right of physicians to practice, if they wish, as salaried members of hospital staffs and to be compensated accordingly (2) assuring to hospitals compensation covering services rendered by salaried physicians on their staffs (3) assuring to patients the full rights of choice; (4) encouraging group practice.

*Physicians and hospitals.*—Every physician should have access to the facilities of a hospital or a clinic to perform services which are within his professional competence. For this purpose, professional competence should be determined by the hospital authorities and their professional staff, acting under the nationally established standards.

Under laws effective in most if not in all States, and according to the prevalent practice in all hospitals which are organized on a nonprofit basis, the hospital governing board has the legal responsibility of appointing the staff physicians and of ratifying the professional standards adopted by the organized staff.

This important measure of local autonomy would continue under a national health program. National professional bodies have been active for years in improving the standards of hospitals in general, of hospital staff organization in particular, and of the specialties of medicine. These professional bodies would continue to function under a national health program and the results which they have already achieved should be substantially advanced by the standards and incentives which this program would provide. These bodies would necessarily be utilized in advisory capacities in the administration of the program.

It is recognized that many hospitals today have organized professional staffs which are, however, too loosely organized to limit the professional work of each staff member to the area of his competence. The competitive relations between physicians practicing similar specialties, and between specialists and general practitioners, militate against a fully effective professional organization.

There are also many small hospitals which have little or no staff organization. Considerable numbers of these are proprietary instead of nonprofit institutions. Some of these proprietary institutions are the only hospitals available to their communities.

Much therefore has to be done in order that hospitals shall generally function on a high level as medical service centers.

*Standards.*—Standards for hospitals acceptable to furnish services under national law should be determined by the administrative authority with the advice of a council familiar with professional services and with hospital administration.



Hospitals should be acceptable for either an unrestricted or a limited scope of service.

Standards for unlimited service should have regard to the quality and scope of the professional care available through the hospital. Standards for limited service should consider also the hospital's size, and the other hospital facilities which are accessible to the people of the area, or which could be obtained by affiliation.

Hospitals range from large, fully equipped and completely staffed institutions to small local units with minimum facilities. Standards should take into account not only the institutions as such but also their coordination. Standards should require, or at least encourage, arrangements among hospitals on a regional basis, whereby the smaller institutions shall be aided by the larger, in diagnostic services, in the care of referred patients, and in educational opportunities for staff physicians.

*Teaching hospitals.*—Special provisions should be made for meeting the needs and maintaining the standards of hospitals which are directly associated with medical schools and which are therefore largely concerned with teaching medical students and with the pursuit of research.

*Hospital construction and improvement.*—The heavy cost of constructing new hospitals where needed, and of enlarging and improving existing institutions, is not infrequently beyond the private or public means of the locality. As previously stated, where private funds are unavailable or insufficient, public funds should aid, from Federal, State, or local sources, or a combination of these. Before public aid is given, the area to be served by a hospital should be determined by competent investigation and a type of organization should be required which conforms with the standards approved by national hospital and medical bodies. Conformity with these requirements would assure maintenance income from the care of patients under the national health program.

In small communities, medical or health centers providing office space for physicians, for diagnostic facilities, and for public-health work may be appropriate. Such centers may be without hospital beds, or may have a few beds for emergency use; provided arrangements can be made for bed care in an accessible affiliated hospital.

*Payments to hospitals.*—In compensating hospitals under a national program which includes all or a great majority of the population, the income of hospitals will be mainly derived from services rendered to beneficiaries of the program, and, consequently, the payments from the health-insurance fund must be sufficient to support hospital services of high quality.

The methods and rates of payments to hospitals must therefore be worked out by the public authorities with agencies representing the hospitals of a given area, or (when necessary) with individual hospitals, with recognition of four principles:

- (1) The hospital's administrative independence is to be maintained.

- (2) The hospital is entitled to remuneration covering the reasonable cost of furnishing a high quality of service of the type required.

(3) Cost should include professional services insofar as these are furnished by salaried physicians.

(4) The public authorities are entitled to require reasonable economy by the hospital in administering its services, judged by a body in which both the public and the hospitals should be represented, and which should include persons familiar with professional services and with hospital administration.

#### IX. ADMINISTRATIVE ORGANIZATION

It is assumed that the financial side of the system of medical care will be closely related with other branches of social security. The form of the administrative organization will necessarily be influenced by this relationship, for the professional and the financial aspects must be coordinated. The health program, of course, includes much more than the collection, pooling, and equitable disbursement of funds. It involves also the furnishing of highly skilled personal services by important professions and institutions. These are already organized in a complex variety of units, local, State, and national, voluntary and governmental. The organization and administration of the health program must therefore be determined by some elements which are peculiar to itself and which are not shared with other branches of social security.

No attempt is made to blueprint administrative organization. Only some principles are stated, relating to (a) the determination of policies, (b) administrative responsibilities, and (c) advisory bodies.<sup>4</sup>

Three basic principles, already outlined, may be restated here:

1. National collection of funds, integrated with the collection of funds for other branches of social security.

2. Local and State administration of services under national standards and national supervision.

3. Unified administration of the medical services; or, where unification is not feasible, machinery for coordination to be established. Especially important is coordination between public health work and medical care.

*Policy making.*—The national policy-determining body for the health program should be representative of the chief groups of those who receive service and of those who furnish it. The same procedure should be followed at local and intermediate levels.

All policy-determining bodies and officials should be responsible to the general public interest as distinguished from the interests of any vocational or economic group.

Local bodies should function in their respective areas according to similar principles.

*Local responsibility.*—The local administrative organization, covering so far as possible a "functional area" as defined on page 10, should be the administrative unit and foundation of the national system. It would necessarily be related to the governmental agencies of the locality, the State, and the Nation. It would work under

<sup>4</sup>The American Public Welfare Association has adopted policies and principles for the administration of tax-supported medical care which will be helpful at certain points for those concerned with prepayment plans serving any large groups of the general population (Organization and Administration of Tax-Supported Medical Care. A Tentative Statement of Essentials and Principles, approved December 1939 by the board of directors of the American Public Welfare Association, Chicago, Ill.).

the national standards. It might be contiguous with a single local political subdivision, or it might—and in most instances it should—include several such political subdivisions. Even so, contractual relations with other units would frequently be necessary in order to obtain certain special services. It would be the duty of the national bodies to work out the areas and their organization with the State and local agencies.

The area from which a hospital draws patients (its "service area") is usually larger than the city or county in which it is located and not infrequently crosses State lines. The authorized service area of a hospital under the national system should correspond as nearly as possible with its natural service area, and arrangements to this effect should be worked out as far as practicable by the governmental and voluntary bodies concerned.

The organizations functionally concerned with medical services in a locality are numerous and vary considerably from area to area. Among such agencies, on the side of those who supply service, are medical societies; private medical groups; voluntary hospitals and clinics under church, industrial, or general auspices; governmental hospitals; hospital staffs; medical-school faculties; health departments. On the side of those who receive service are local public bodies or officials representing political subdivisions; employee groups, especially labor unions; employers; farmers' organizations; some cooperative and fraternal agencies. Many public welfare and some local public health departments may be in the position both of furnishing certain services and also of paying hospitals and physicians for services furnished some members of the community.

The local administrative organization in any area should carry out the preceding principles by including in its consultative body through which local policy must be guided, representatives of the chief groups and agencies which are directly concerned with medical services as well as the general public. Agencies of local government, and especially the public health department, are of course to be included.

*Administrative responsibilities.*—Administrative responsibility should be divided functionally, on the operating level, between the professional and the financial fields.

The administrative officials should be appointed by and responsible to a public body or official and should be removed as fully as possible from partisan political pressures.

The administrators of all professional and technical aspects of the program should be qualified professional persons. The professional and the financial officials should each have administrative authority in his respective field. The two agents must work together in those numerous matters wherein the two groups of functions are mingled, coordinated through the policy-determining body, which will represent both interests as well as the general public.

In local areas, the professional and financial functions would likewise be performed by two administrative officers, respectively, coordinated through the local consultative body described above and through officials at national and intermediate levels.

*Advisory bodies.*—The policy-determining body and the administrative officers should be aided by advisory councils composed of informed persons from professional and lay groups.

Medical care and hospitalization involve a variety of diverse elements: medical, financial, and public relations. This wide range of knowledge and interests cannot be represented within the administrative body itself. At least one general advisory body is required, representing the major lay and professional groups. A number of special advisory bodies are also needed to assist in technical matters, e. g., physicians' services; hospitalization; various specialized services; finances.

Advisory councils are needed on the local as well as on the national and intermediate levels.

The advisory councils concerned with general policies should include informed persons drawn from groups of persons who receive and from groups who furnish services.

The councils concerned with specialized matters should be representative of all the major elements within their field.

The members of advisory councils should be appointed for stated terms by the policy-determining body. It is not desirable that councils be appointed by an executive officer whom they are to advise. Boards and executive officers should be required to consult the councils in the preparation and revision of regulations defining administrative policies. Councils should have a budget for secretarial and other expenses and should have the right to hold meetings on their own motion, to initiate suggestions, and to make public their reports or recommendations when they so desire.

There are numerous important regulations which cannot be specified in a law. Some of these regulations may be national in application. Others will be designed for certain localities, or will relate only to particular forms of service. These regulations must be worked out by the administrative authorities and when adopted have the force of law.

It seems important that the advisory councils representing the appropriate functional and geographical interests concerned shall be consulted before the adoption of such regulations, without, however, placing administrative responsibilities on the councils or lessening the responsibility of the boards and executive officers.

## **VI. EXTRACT FROM STATEMENT NO. 16 OF THE COMMITTEE OF PHYSICIANS FOR THE IMPROVEMENT OF MEDICAL CARE, INC.: AN ANALYSIS OF THE HEALTH INSURANCE FEATURES OF THE WAGNER-MURRAY-DINGELL BILL (S. 1050)**

### **DISCUSSION AND RECOMMENDATIONS OF THE COMMITTEE OF PHYSICIANS NATIONAL SOCIAL INSURANCE SYSTEM**

#### **INTENTIONS**

The attention given to the committee's criticisms of the previous bill is a proof of the receptive attitude of the proponents of this bill to constructive suggestions and their solicitude for the quality of medical services, the chief interest of the committee of physicians. The following comments and criticisms are advanced with confidence that they will be received in the same sympathetic spirit.

#### **COVERAGE**

That a program for medical care should ultimately comprehend the whole population has been the opinion of the committee since its inception. The difficulties which attend attempts to provide at one step for the coverage of such an enormous number of persons (100,000,000 to 115,000,000) as this measure contemplates, cannot be minimized. A more gradual procedure would be theoretically advantageous. It might offer opportunity for the development of machinery and administrative techniques by the experimental method and thereby avoid gross initial errors and commitments that would compromise the quality of medical care. No realistic or equitable program for less comprehensive coverage has been found. One of the inherent objections to a less comprehensive program is the necessity for the introduction of a means test. Circumstances have arisen, moreover, that mark this as a most advantageous moment for a radical revision of our system of medical care. As a result of the war the medical services throughout the Nation have been dislocated. Reorganization of these services and relocation of physicians are inevitable. Provision must be made for further education and distribution of physicians. Medical and hospital care must be provided for veterans. It has been pointed out in the last three statements of the committee (Nos. 13, 14, and 15) that only the institution of a comprehensive national program for medical care will offer a satisfactory solution to these problems.

The committee regrets that it has again seemed necessary to exclude from participation Federal employees. Presumably the reasons for this discrimination are the same as before. It is also regrettable that employees of States cannot be automatically included instead of hav-

ing their participation contingent upon special arrangements between the States and the Federal authority. The committee wishes to reiterate that "efforts should be made to extend to these government employees unconditionally at least the medical benefits to which existing arrangements do not entitle them" (statement 12).

The provision that servicemen be given generous credit for their service in the military forces is no more than a fitting acknowledgment.

#### FINANCIAL

The motives which actuated the changes in the size of contributions and the income ceiling and the estimated relation of income by the new provisions as compared to that expected from the previous rates are unknown to the committee of physicians. Presumably the subject has been carefully studied by the Government's actuarial experts. In any case such estimates must be considered as provisional. No one can predict with certainty the extent to which costs of care will be increased by expansion of services nor how far these increases will be offset by reduction of overhead and other economies which may be anticipated from more systematic organization of these services. Much will depend on the wisdom and efficiency with which the system is planned and conducted. Every effort should be made to achieve economy; but the quality of care will suffer if this economy is achieved at the expense of needed facilities and by reducing remuneration for services to such a point that personnel of the desired quality will not be induced to participate in the program or, if they are induced, will not have the time needed for self-improvement. Efforts should be made to improve the unsatisfactory incomes of physicians in rural areas. It is expressly stated under "Methods and policies of administration" below that "methods of payment should be aimed \* \* \* to provide professional and financial incentives to professional advancement of practitioners; to encourage high standards of quality of service by adequate payment to practitioners \* \* \*." If this policy prevails it may be expected that errors in present estimates will be rectified.

#### ADMINISTRATION OF CONTRIBUTIONS

Provisions for a trust fund and its administration need no particular comment.

#### HEALTH AND MEDICAL PROVISIONS

##### ADMINISTRATION

*Authorities.*—As before, administrative authority is vested in the Surgeon General of the Public Health Service. It has always been the opinion of the committee of physicians that a single centralized Federal authority is essential and that the Surgeon General of the Public Health Service is the most appropriate authority in our present governmental structure. Since the health measures are linked with social security measures that are not related to the functions of the Public Health Service, parallel administrative authority must be given to the Social Security Board. This necessitates some higher authority to which both the Public Health Service and the Social Security Board are responsible. For this office the Federal Security Administrator

has been selected and has been endowed with almost absolute veto powers, without the provisions for appeal that exist throughout lower levels of the administrative structure. Such an ultimate authority is probably inescapable. Intelligent appointment and informed public opinion will have to be relied on to insure the wise use of these powers.

*Advisory Council.*—The composition, methods of appointment, functions, and responsibilities remain essentially as before. The committee of physicians expressed its general approval of these provisions. Provision is made that there be some representation of the beneficiaries in the Medical Policy Council. This would appear to be an equitable provision. It is specified in various sections of the bill that in some instances consultation with the Advisory Council is mandatory upon the Surgeon General, in others it is elective. With respect to a few matters the initiative is given to the Council. On the whole the authors of the bill have shown good judgment in adopting for each provision the most appropriate of these formulae for the allocation of initiative. Since this Council properly has only advisory functions the committee has held that special provisions should be made for publication of its decisions, recommendations, and studies, to lend force to these recommendations, and to deter the authorities from disregarding them. In the present measure the Surgeon General is directed to include a record of these consultations, reports, recommendations, etc., in his report to the regular session of each Congress. In a matter of such concern to the people at large and one in which reports are likely to be of such general interest and may often have economic and scientific importance, the public interest would be better served if provision were made for the regular publication of reports by the Council on matters which it feels should be called to the public's attention. The right to issue such reports should reside with the Council, unconditioned by the approval of any authority.

The provisions for the institution of special and regional councils and committees and the provisions for appeal bodies and their procedures seem adequate.

#### MEDICAL AND HOSPITALIZATION BENEFITS

These again follow the pattern of the previous bill with a few notable exceptions to which attention will be drawn.

The personal health benefits are defined in the same unexceptionable terms.

*Limitations on benefits.*—Objections must again be raised to the provisions in section 210, page 91, authorizing the Surgeon General to limit practitioner's and laboratory services. As we said concerning similar provisions in the last bill: "The exception of first visits from coverage under the bill violates the principles of preventive medicine. It acts as a deterrent to the early treatment of disease, thereby tending to prolong disability. Limitation of laboratory benefits will be a detriment to the best medical care. These exceptions are intended to prevent abuse of the system. Payment of extra fees to physicians for excepted services will aggravate such abuses, because the physician will profit by increasing the number of such exceptional services, while the beneficiary can reduce them only by foregoing what may be an essential item of medical care. These abuses can be more effectively

eliminated by establishing sound principles for the program as a whole and efficient administration."

The limitation of general and special dental benefits, though undesirable, may be unavoidable at the present time. To undertake in any new program to provide the salvage work necessary for the complete dental rehabilitation of the adult population by existing techniques would be beyond the capacity of the available personnel and facilities and probably prohibitively costly. The minimum services available after January 1, 1947, appear well considered. The proposed preferential treatment of children may make it possible in the future to incorporate complete dental care in the program.

Provision of home nursing poses another knotty program. Wisely, special provisions have been made for the study of this service and dental services.

In the last bill drugs were not included among benefits, but it was provided that their inclusion at a later date might be possible. In the present bill they are not even mentioned. The committee repeats that such important therapeutic instruments should not be excluded without consideration, but should be made a subject of special study by the Council with a view to appropriate action.

*Methods and policies for administration.*—The formula for the designation of specialists and consultants remains essentially unchanged. The committee still feels that "on the certification of specialists the exclusive utilization of standards and qualifications developed by competent professional agencies is open to objection. The Government cannot properly delegate selective powers to self-perpetuating nongovernmental bodies over which it has no control. The standards and certifications of these agencies could, like any other relevant data, be employed by the Council, but their use should not be prescribed in the bill." Besides, as it was pointed out, these agencies prescribe standards and certify physicians only for the exclusive practice of a specialty; whereas it will be necessary in the contemplated program to broaden the definition of specialists to meet local conditions and particular medical problems. Such a broad definition of specialists is necessary to assure the development of the more highly qualified specialists.

The provision for appeal by a beneficiary if his practitioner will not recommend the services of a specialist or consultant is a necessary protection for the patient.

The provision that groups as well as individual practitioners be included in the lists to be published by the Surgeon General corrects a grave error.

Fee-for-service payment is still listed among the permissible methods of remuneration for physicians. The choice of a method of payment for practitioners in a given area is also still to be determined by the majority of general medical practitioners in the area. It is, however, provided that the Surgeon General shall make arrangements by which the minority may be enabled to practice under the system of payment that is most satisfactory to each. It also grants special consideration to groups and particularly to groups organized about hospitals. It was pointed out, in both statement 12 and statement 15, that without such a provision, if the physicians of an area elected fee-for-service payment, teaching hospitals and other institutions with



salaried staffs would be unable to participate in the program. Although the committee of physicians still feels that inclusion of fee-for-service payment is extremely regrettable, if it cannot be excluded because of the pressure of organized medicine and the uninformed state of public opinion, the proposed compromise is satisfactory. It will establish competition between individual practitioners, groups, and hospital organizations on fee-for-service or other bases of payments, permitting each to demonstrate its superiority. The declaration that "The methods of administration, including the methods of making payment to practitioners, shall \* \* \* provide \* \* \* coordination among the services furnished by \* \* \* practitioners, hospitals, public-health centers, educational, research, and other institutions, and between preventive and curative services \* \* \*" is a profession of real significance.

*Hospitalization.*—The period of hospitalization has been extended from 30 to 60 days in a benefit year, with possible prolongation to 120 days (instead of 90) if the funds prove sufficient. With the increasing use of hospitals for therapeutic courses this is a change in the right direction.

The definition of hospital benefits remains vague. There is almost a contradiction between the statement that in order to participate in the system hospitals must "meet general standards prescribed by the Surgeon General" and the statement that "The Surgeon General shall exercise no supervision or control over a participating hospital \* \* \* nor shall any requirement \* \* \* prescribe its administration, personnel, or operation." Confusion is not diminished by the definition of a participating hospital in a subsequent section. As in the last bill no separate consideration is given to the payment of practitioners in hospitals. Provision must be made for the care in the hospitals of patients referred by practitioners who have no hospital privileges.

In its discussion of the previous bill and in its statements 13 and 15, dealing respectively with the Hill-Burton bill and with education, the committee of physicians has advocated that participating hospitals be required to have salaried medical staffs and that payment be made to hospitals for complete care of patients, including remuneration of physicians for their services. The funds allocated for hospital care and associated social services should, however, be distinguished from those allocated for medical services, which should be reserved for payment of members of the medical staff.

The present bill does permit the Surgeon General to make contracts with participating hospitals for such inclusive services. It does not, however, prescribe that payments for physicians' services in these hospitals should be reserved for this purpose and should be made at prevailing rates. Without such specific provisions institutions might be tempted to compete on a basis that would lead to exploitation and economic debasement of physicians. Care should be taken that the distribution of the funds earmarked for physicians' services is not so specifically prescribed that proper organization and rewards for varying competence and utility would be prohibited.

The general increase of maximal rates for hospital benefits manifests a realistic appreciation of the growing costs of hospitalization with the development of new techniques and the demand for more ex-

pert services. Although the contemplated grade of hospital services is nowhere explicitly defined, it seems to be implicitly described in the clause "for the cost of essential hospital services, including the use of ward or other least expensive facilities compatible with the proper care of the patient," found in the authorization of the Surgeon General to enter into contracts with hospitals. If the system is to serve the population at large it is evident that many of the economically fortunate will prefer semiprivate or private accommodations. For this reason it is provided that participating hospitals may "require payments from patients with respect to the additional cost of more expensive facilities furnished for lack of ward facilities or occupied at the request of the patient, or with respect to services not included within a contract." Without such a provision such patients would be deprived of hospitalization benefits under the special contingencies mentioned. Payments for physicians and other personal services must not be treated in a similar manner. Recognition that the quality of such personal services could vary with remuneration would be intolerable.

#### DISABILITY BENEFITS

These provisions, similar to those of the last bill, are excellent. The method of certifying disability, always a knotty problem, is entrusted to the Surgeon General in consultation with the Social Security Board and is recommended to the consideration of the Medical Policy Council.

#### WORKMEN'S COMPENSATION

The provision that insurance benefits cannot be used in lieu of payments for injury or disability covered by workmen's compensation is eminently sound. These acts have proved invaluable weapons in the reduction of industrial hazards. Nevertheless, if the system of medical care is to be largely conducted under the insurance system, it would be unfortunate to exclude persons who have incurred illness or disability for which compensation is authorized from the privilege of using the machinery of the social insurance system. In fact it may be anticipated that to deprive them of this privilege, as the system grows, might prevent them from obtaining proper care. It is, therefore, important to make this machinery available to them so long as payment for services is made from the sources and at the rates required by compensation acts.

#### GRANTS-IN-AID FOR MEDICAL EDUCATION, RESEARCH, AND PREVENTIVE MEASURES

The committee again endorses the consideration given to education and research, without which the quality of medicine will not improve. The importance of educating medical officers discharged from the military services cannot be questioned, but the wisdom of diverting to this purpose for 5 years grants intended for research may be. Some other expedient should be found to rectify errors of the past, the fundamental efforts of research and education should always be directed to the future.

DENTAL, NURSING, AND OTHER BENEFITS: CARE AND PREVENTION FOR  
CHRONIC SICKNESS AND MENTAL DISEASES

The difficulties of including full dental and nursing care in the program have been mentioned. Chronic sickness and mental diseases present somewhat similar problems. A painstaking study of these problems is a necessary antecedent to their solution, which the committee of physicians hopes may be found.

Committee of Physicians for the Improvement of Medical Care, Inc.: Channing Frothingham, chairman; Milton C. Winternitz and Carl Binger, vice chairmen; Russell L. Cecil, honorary chairman; John P. Peters, secretary and treasurer; Alf S. Alving; Bertram Bernheim; Ernst P. Boas; Samuel Bradbury; Allan M. Butler; Alexander M. Burgess; Louis Casamajor; Thomas B. Cooley; Robert L. DeNormandie; Nathaniel Faxon; Charles A. Flood;<sup>1</sup> Maurice Fremont-Smith; Harry Goldblatt; F. T. H'Doubler; William J. Kerr; H. Clifford Loos; F. D. W. Lukens; George M. Mackenzie; Harry S. Mackler; Irvine McQuarrie; J. H. Means; T. Grier Miller; George R. Minot; Fred D. Mott; Robert B. Osgood; Walter L. Palmer; H. B. Richardson; G. Canby Robinson; David Seegal; Clement A. Smith; Richard M. Smith; Joseph Stokes, Jr.; Borden S. Veeeder; Allen O. Whipple; James L. Wilson; W. Barry Wood, Jr.; Edward L. Young. John P. Peters, M. D., secretary, 789 Howard Avenue, New Haven 11, Conn.

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<sup>1</sup> U. S. Army.

## **VII. STATEMENTS OPPOSING HEALTH INSURANCE BY THE NATIONAL PHYSICIANS COMMITTEE FOR THE EXTENSION OF MEDICAL SERVICE**

### **A. POLITICAL MEDICINE AND FREEDOM OF ENTERPRISE**

#### **THE CONTINUING THREAT OF COLLECTIVE CONTROL**

**A factual statement on the compulsory health insurance provisions of the social security amendments of 1945 (Wagner-Murray-Dingell S. 1050, H. R. 3293) and an explanation of some of their meanings and implications**

#### **THE SOURCE OF STRENGTH**

The war has shown us that we have tremendous resources to make all the materials of war. It has shown us that we have skillful workers and managers and able generals, and a brave people capable of bearing arms.

The new thing—the thing we had not known—the thing we have learned now and should never forget—is this: That a society of self-governing men is more powerful, more enduring, more creative than any other kind of society, however disciplined, however centralized.

We know now that the basic proposition of the worth and dignity of man is not a sentimental aspiration or a vain hope or a piece of rhetoric. It is the strongest, the most creative force now present in this world.—HARRY S. TRUMAN, President of the United States, in Report on Potsdam Conference.

#### **FOREWORD**

Within the last 4 years we have won two wars.

The basic tenet of the American people has been, from the first beginnings, the Christian concept of the individual right above that of the state, the sanctity of human personality. The freedom-of-enterprise system—the profit motive in industry and commerce—are inherently a part of this concept.

This system, through operation over a period of more than a century, provided this Nation with the imagination, the know-how, the ingenuity, the skills, and the stamina that resulted in limitless production of superior instruments of destruction. Such was the need of the time. This concept provided the incentives which made possible universal mobilization of manpower and resources for the waging of total war. It gave to this Nation the atomic bomb. "It is the strongest, the most creative force now present in this world."

Yet, while finally tested in competitive world conflict, wholly vindicated and gloriously triumphant, this concept is held suspect by the whole of the rest of the civilized world. They do not understand or even remotely comprehend this source of strength and of power. The United States stands alone, an isolated island of free enterprise in a vast tumultuous ocean of socialistic and collectivist thought.

In this country there are many who still profess to believe that the common good can be best served through centralized collectivist con-

trol. Continuously they strive to establish bridgeheads of collectivism from which to extend operations. The most dangerous among these are the advocates of compulsory health insurance, now before Congress in the Wagner-Murray-Dingell bills.

On the basis that has been proposed, compulsory health insurance means state medicine—the political distribution of medical care. It would entail the establishment of a vast army of bureaucrats that would become the determining authority in the most delicate and sacred matters affecting every human being in this country. It would create an atmosphere and an environment in which free enterprise in any of its forms could not long survive.

Every American—every believer in the American way of life—should join in opposition to this effort to foist on the American people this strictly collectivist mechanism, compulsory health insurance.—J. M. P.

#### POLITICAL MEDICINE AND FREEDOM OF ENTERPRISE

Wagner-Murray-Dingell bills (Senate 1050, H. R. 3203)

The key provisions—compulsory health insurance—of the Wagner-Murray-Dingell bills, social-security amendments of 1945, are truly revolutionary in their implications. They are more far-reaching than any proposals ever previously presented in the United States Congress. They are more comprehensive than any measures enacted into law in any country with the possible exception of Russia.

They not only represent a departure from all precedents but they would establish a governmental machinery and administrative mechanism that are truly collectivist in concept. They stem from the Sir William Beveridge recommendations for making all British citizens dependent on the state for security. They are wholly alien.

If our way of life is to be preserved, Americans must take time to understand and appraise these proposals. Every strength must be mobilized and concentrated in opposition to the menacing sections until they are finally and totally defeated. There must be an unconditional surrender. The alternative is the sacrifice and final forfeiture of our priceless heritage.

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#### HEALTH INSURANCE

Under this heading the Wagner-Murray-Dingell bill departs from all precedent and, under the guise of sheer altruism, would establish a wholly socialistic device to attempt to provide full "personal health services" for all social-security beneficiaries and all of their dependents—110,000,000 people.

It would establish the Surgeon General of the Public Health Service—under the direction of the Administrator of the Social Security Board—as a medical dictator, under orders to provide the services and with full authority to:

1. Hire doctors, specialists, dentists, nurses, laboratory technicians, and establish rates of pay.
2. Establish fee schedules for physicians' and dentists' services.
3. Fix the qualifications for specialists.
4. Determine the number of individuals for whom any doctor or dentist may provide service.

5. Determine what hospitals or clinics may provide service for patients and under what conditions.

The operation would entail making a public record of the characteristics and the most intimate and sacred personal relationships of each and every patient. The privacy of every human being would be invaded and violated. It can be imagined how the information might be used by the curious and the unscrupulous.

#### *The benefits*

The personal health service benefits which this medical "fuehrer" must provide would include a general medical service, special medical benefit, general and special dental services, hospitalization, laboratory services, and home nursing. The meaning of these various services is fully explained under "definitions" below. They should be carefully studied.

#### *The tax*

The over-all social-security tax is to be 8 percent of wages up to \$3,600, 4 percent to be paid by the employer and 4 percent by the employee. Self-employed individuals are to pay 5 percent of "the market value" up to \$3,600 of their services. In the case of State and local governments coming into the system, the tax is 5 percent, 2½ percent being paid by the government unit and 2½ percent by the employee. It is estimated that this total tax will produce approximately \$10,000,000,000 annually.

#### *For personal health services*

Of the taxes levied, 3 of the 8 percent tax, or 37½ percent of the total (approximately \$3,142,000,000 a year) is to be earmarked to provide personal health services. This stupendous sum is to be supplemented by appropriations from general revenue.

#### *The fundamental distinction*

Under the Wagner-Murray-Dingell provisions it is proposed to:

1. Appropriate funds for the construction of hospitals and health facilities. Payments are to be made in cash.
2. Provide grants to States for public-health services. Payments are to be made in cash.
3. Provide grants to States for maternal and child health and welfare service. Payments are to be made in cash.
4. Provide grants to States for more comprehensive public assistance for the needy. Payments are to be made in cash.
5. Provide grants to nonprofit corporations and agencies engaged in research or in undergraduate or postgraduate professional education (estimated amount \$30,000,000 annually). Payments are to be made in cash.
6. Reimburse workers during periods of unemployment and for temporary disability. Payments are to be made in cash.
7. Provide monthly retirement benefits for all male workers having reached the age of 65 and female workers having reached the age of 60. Payments are to be made in cash.
8. Provide monthly benefits for widows, mothers, parents, and dependent children of workers. Payments are to be made in cash.
9. Provide lump-sum payments to widows, widowers, or heirs on the death of workers. Payments are to be made in cash.

10. With it comes the revolution—provide personal health services for all social-security beneficiaries and their dependents. No cash payments are made.

Instead, the Surgeon General of the Public Health Service, under direction of a layman—the Federal Security Administrator—is to hire or otherwise secure the services of doctors, specialists, dentists, nurses, and laboratory technicians. He is to arrange to secure and pay for hospital, clinical, and other medical facilities.

He is to provide full personal health services, as herein defined below, for 110,000,000 people. In effect, the Federal Government would establish tens of thousands of retail establishments and conduct the business of providing medical, dental, and hospital care.

One man, the Surgeon General of the Public Health Service, would become the dispenser of all health care and the final arbiter of the mental and physical well-being of the Nation.

#### *Appraisal essential*

These proposals should be recognized for what they are. They are in reality state medicine. If enacted into law and made fully effective they would—

(a) Place all doctors and dentists under direction of a bureaucrat—regiment the medical, dental, and nursing professions.

(b) Destroy the private practice of medicine and dentistry in the United States.

(c) Inevitably result in a deterioration of the quality of medical and dental care.

(d) By a reasonable progression, necessitate the Federal Government conducting the business of producing drugs, pharmaceuticals, eyeglasses, appliances, hospital equipment, and supplies.

(e) Establish a core of collectivist control that surely will be extended, and under which free enterprise in any field could not long survive.

#### *American medicine*

Under the American system, American medicine—American doctors—have developed the most effective and the most widely distributed medical care that has ever been provided for any comparable number of people anywhere at any time.

Free men—with fearless minds—progressively provided a higher and higher quality of medical care. This better and better medical care has been continuously more widely distributed and made more generally available.

Through Blue Cross, physician-sponsored medical-service plans, and employer-employee group insurance programs more than 25,000,000 people are now provided with needed protections. The expansion of these services will provide other tens of millions with means for the easier payment of the cost of medical care. Through voluntary methods steps have been taken to bring to every American more effective medicines and medical procedures than were ever before known or imagined.

#### *The basic tenet of the doctor*

The basic tenet of the medical profession is “the most effective medical care for every human being regardless of race, color, social position, or financial status.”

However, the doctor is a human being—a personality. His tradition, his knowledge, and his experience make him more sure and more confident than his fellow men. He must be free to act as an individual. He dare not be robbed of his freedom of action and decision. Bureaucratic direction would destroy the intangible, indefinable essence that is the secret of his effectiveness.

*The all-important issue*

Communism, fascism, nazism, collectivism in any of its forms are not mere matters of terms or definitions. They result from the establishment of centralized controls and the operation of mechanisms of administration. Unfortunately, in the development of these mechanisms the insidious step by step procedure may postpone recognition of their real significance. The Wagner-Murray-Dingell compulsory health-insurance proposals are strictly collectivist in form and intent. They would provide a most potent instrumentality of the collectivist state.

In this country at this time there is a leadership of groups that would personally profit by the centralizing of controls. They would become the Gauleiters or the subfuhrers of a new order. These are the sponsors and chief supporters of compulsory health insurance.

We are faced with a real crisis more menacing than any that has gone before.

We have won two wars. We must convert a war-production plant to serve peacetime civilian needs. There must of necessity be a period of confusion, dislocation, and unemployment. It may last 6 months, 9 months, or a year before there is the prospect of leveling off to normal production and full employment.

Under these conditions political pressures are being brought to bear—almost irresistible pressures—to force to passage this basic issue of compulsory health insurance during this period of confusion and uncertainties.

This is not a matter which affects doctors, dentists, nurses, and medical technicians only. The regimentation of these professions inevitably would lead to the control of all professions. It would lead quickly to the Government production of drugs and medicines, medical and hospital supplies, and equipment.

This production could not be undertaken without establishing the principle of "production for use"—no profit. All of the professions, all business, and all industry are directly affected. Every human being would be victimized. Incentives would be destroyed—personal initiative ruthlessly suppressed. A combined strength is necessary if these efforts of the collectivists in our midst are to be thwarted.

This combined strength—confident and aggressive—is essential if we are to preserve in this country our priceless heritage: The individual right as superior to the state—the system of freedom of enterprise.

\* \* \* \* \*

Of the 185 pages of the Wagner-Murray-Dingell bills, 183 pages are devoted to preachment, propaganda, provisions, and benefits. Only 2 pages are devoted to assessing the largest tax ever levied by this or any other country for a single purpose—\$10,000,000,000 annually.

\* \* \* \* \*



## HEALTH SECURITY PROGRAM

*The National Physicians' Committee for the Extension of Medical Service*

The management committee has been instructed by the board of trustees to take all necessary steps designed to:

(a) Encourage the medical profession to active participation in the development of plans and the more general use of existing facilities to provide for easy payment of insurance against unusual or prolonged illness;

(b) Educate the people to the importance, nature, and value of prepayment facilities (within the framework of principles approved by the medical profession), now available for meeting the costs of unusual illness;

(c) Investigate conditions relating to and inform industry concerning the principles underlying sound participation with employees in prepayment plans for meeting the cost of unusual or prolonged illness and hospitalization;

(d) Inform private insurance underwriters of the opportunity that is being offered through cooperation in Nation-wide efforts to provide group-insurance policies for those needing or desiring insurance against the hazards of unusual illness;

(e) Encourage the more generous use of Government funds administered at State and local levels to insure effective medical care for the indigent;

(f) Encourage contributors and friends to a greater degree of participation in the efforts of the National Physicians' Committee in this constructive program.

The National Physicians' Committee is utilizing to maximum capacity its resources and organizational strength in ceaseless effort to preserve in the United States our system of private enterprise to the end that doctors of medicine may retain, in the public interest their personal independence—their individual and collective integrity and effectiveness.

Understanding of purpose is sought and cooperation is welcomed in the belief that joint efforts will result in the attainment of these objectives.

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NATIONAL PHYSICIANS' COMMITTEE FOR THE EXTENSION OF MEDICAL SERVICE

A nonpolitical, nonprofit, organization devoted to—

1. The task of securing the most widespread distribution of the most effective methods and equipment in medicine and surgery.

2. Familiarizing the public with the facts in connection with the values, the methods and the achievements of American medicine.

Maintained exclusively by voluntary contributions.

Needing, for maximum effectiveness, the systematic, organized support of all county and sectional medical societies, insurance underwriters, and interested units of business and industry.

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Administrator, John M. Pratt

### B. THREE BILLION FORTY-EIGHT MILLION DOLLARS OF POLITICAL MEDICINE YEARLY IN THE UNITED STATES—WHAT DOES IT MEAN FOR SICK PEOPLE, THE DOCTORS, THE PUBLIC?

NATIONAL PHYSICIANS' COMMITTEE  
FOR THE EXTENSION OF MEDICAL SERVICE,  
*Pittsfield Building, Chicago.*

One reason why the compulsory state seems to be gaining on us is defeatism among the vast majority who don't want any part of it. We have been told so often and so emphatically that collectivism is inevitable that we have come to believe it, as if some strange bacterial growth were gnawing at our economic vitals and it was too late for an operation. Investigation of specific symptoms usually reveals that the only inevitable feature of the march toward collectivism is the determination of the little group which wants to collectivize us.—*The Saturday Evening Post.*

Often human life depends upon a physician's skill—shall he be made subservient to politicians?

#### POLITICAL MEDICINE FOR AMERICA

On June 3, 1943, Senator Robert F. Wagner, of New York—for himself and Senator James Murray, of Montana—introduced in the Senate, bill 1161.

If the recommendations in this bill are enacted into law, they will destroy the effectiveness of medical care in the United States.

The bill proposes to raise annually by taxation—from pay rolls mostly—approximately \$12,000,000,000. Of this sum an amount estimated at \$3,048,000,000 is to be allocated to provide medical care by the Government.

#### ONE-MAN MEDICAL CARE

The bill proposes placing in the hands of one man—the Surgeon General of the Public Health Service—the power and authority—

1. To hire doctors—possibly all doctors—at fixed salaries to provide medical service;
2. To designate which doctors can be specialists;
3. To determine the number of individuals for whom any physician may provide service;

4. To determine arbitrarily what hospitals or clinics may provide service for patients.

It instructs the Surgeon General to provide general and special medical care, laboratory tests, and hospitalization for all beneficiaries of the Social Security Act and their dependents—estimated at 110,000,000 people.

#### WHAT COULD HE DO?

It is estimated that, at the present time, there are in the United States, available for civilian practice, 120,000 effective physicians. With \$3,000,000,000 the Surgeon General could—

a. Allocate 20 percent for administration costs-----	\$600,000,000.00
b. Hire every effective physician in the United States at an average salary of \$5,000 a year-----	600,000,000.00
c. Pay for every available bed in every non-Government-owned hospital (308,046) 305 days each year (134,330,790 hospital bed-days) at \$5 per day-----	671,683,950.00
d. Pay \$2.50 per day for each and every Government-owned hospital bed (1,051,781) 365 days in the year (383,900,065 hospital bed-days)-----	959,750,162.50
e. Spend for drugs and medicines-----	168,505,887.50
	<hr/>
	3,000,000,000.00

It is obvious that if these proposals become the law of the land, they will destroy the entire system of medical care as we have known it in the United States.

#### WHAT HAS AMERICAN MEDICINE DONE?

Under the American system, American medicine—American doctors—have developed the most effective and the most widely distributed medical care that has ever been provided for any comparable number of people anywhere at any time.

In 150 years the average number of years a man will live has been nearly doubled. In 1790 the average was 35 years. Today it is 62 years.

A child born in 1942 has the prospect of living 12 years longer than a child born in 1900.

In the last 40 years the death rate per 100,000 people has been reduced from 1,755 to only 1,060.

During this period typhoid fever almost has disappeared; smallpox has been subdued; diphtheria practically has been conquered; pernicious anemia, tuberculosis, diabetes, and a score of lesser ailments are being brought under control.

In 1942 the United States had the highest general level of health and the lowest death rate ever known for a like number of people under similar conditions.

#### WHAT DOES POLITICAL MEDICINE MEAN FOR DOCTORS?

Doctors would be paid by Government. Presumably they would work 8 hours per day instead of 24 hours.

There would be little incentive for the doctor to become skilled in the art of medical practice. His advancement would depend upon his influence with politicians rather than on his skill or the character of his work.

The doctor would not develop initiative—he would have to adopt the methods and prescribe the treatments and medicines determined by superiors.

The doctor would have little, if any, personal interest in the patient who is compelled to visit him.

State medicine—political control of medical service—always has, always will develop doctors who are politically amenable, who cater to the ward committeeman or the precinct captain rather than to the needs of human beings who are their patients.

For the doctor, political control of medical care means incompetence, professional deterioration, and the forfeiture of self-respect.

#### WHAT DOES POLITICAL MEDICINE MEAN FOR SICK PEOPLE?

It means that they must depend upon a doctor who—

Is paid by the Government—presumably working 8 hours per day. The emergency sickness must wait until the doctor is on the job.

May not be the doctor of their choice but the one that has been assigned by a political bureaucrat.

Cannot have a personal interest in patients who come to him; because they are compelled to do so.

Is less knowing and less efficient because he must follow methods and prescribe remedies that are fixed by his bureaucratic superiors.

Since his job is political, is more interested in pleasing or appeasing his political bosses than he is in curing his patients.

#### THE QUESTION

Unless a tidal wave of protest forewarns the sponsors, this bill or similar proposals may be enacted into law. The question to be answered is a simple one:

Do you want medical care for the sick to be provided by bureaucrats, politicians, or by doctors?

#### WHAT DOES POLITICAL MEDICINE MEAN FOR THE PUBLIC?

Three billion dollars annually of extra pay-roll taxes—an average of about \$120 yearly for each family;

One hundred and fifty thousand additional bureaucrats to tell patients where to go and doctors what to do and how to treat human beings who are sick;

The sacrificing of the highest level of health and the most effective medical care ever known;

Doctors—to care for loved ones—who are first political stooges and henchmen instead of self-respecting human beings and—it is understood that, if the medical profession is regimented, it will represent a decisive step forward toward establishing centralized Federal control of all the professions and industry, and the destruction of freedom of enterprise in the United States.

This issue must be decided by the people—the voters of the United States. Make your decision. Show this to your neighbor. Talk to him about it. Talk or write to your Senators and Congressmen.

THE NATIONAL PHYSICIANS COMMITTEE FOR  
THE EXTENSION OF MEDICAL SERVICE,  
*The Pittsfield Building, Chicago 2, Ill.*

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C. EDITORIALS FOR EDITORS DISTRIBUTED BY NATIONAL PHYSICIANS  
COMMITTEE

THE MEDICAL-CARE ISSUE

In this vitally important folder are reproduced five of a series of Editorials to Editors.

These were objectively prepared to make clear the point of view of the medical profession in connection with the vital issue of the political distribution of medical care. They call attention to the broader implications of such proposals.

No. 2 of the series explains the fundamental distinction between existing social security benefit concepts and the revolutionary procedures involved in proposals to establish the Federal Government as the sole dispenser of medical care.

No. 3 attempts to define the distinguishing characteristics of American medicine.

In view of the introduction of new and far-reaching social-security amendments, No. 5 may be considered as the most important of the series.

All of these editorials previously have been published as advertisements in Editor and Publisher and other newspaper trade publications. They are submitted in this form in order that all who are interested in preserving our system of private medical practice may have evidence of the steps that are being taken to clarify this issue for the newspapers of this country.

*(Permission to reprint any portion of contents of this folder is hereby granted.)*

NATIONAL PHYSICIANS COMMITTEE.

STATEMENT OF POLICY

"It is essential that we understand that, to the extent we move toward a form of fascism, nazism, communism—totalitarian control—will we affect the practice of medicine in the United States. Under any form of Government, social and economic structure, medicine must and will occupy merely its relative place.

"If the independence of medicine, our doctor-patient relationship, and our pattern of medical practice are to be preserved, we must preserve the principles underlying our institutions" (excerpts from policy statement of National Physicians Committee, published November 12, 1940).

The National Physicians Committee is utilizing to maximum capacity its resources and organizational strength in ceaseless efforts to preserve in the United States our system of private enterprise to the end that doctors of medicine may retain, in the public interest, their personal independence—their individual and collective integrity and effectiveness.

Understanding of purpose is sought and cooperation is welcomed in the belief that joint efforts may result in the attainment of these objectives.

#### NATIONAL PHYSICIANS COMMITTEE FOR THE EXTENSION OF MEDICAL SERVICE

A nonpolitical, nonprofit organization for maintaining ethical and scientific standards and extending medical service to all the people

#### NO. 1. GUARDIANS OF A PRICELESS HERITAGE

In this Nation there are vital issues which transcend all partisanship. The American people have a priceless heritage. It is not shared by the people of any other nation. It belongs exclusively to the people of the United States.

This inheritance sets the American people apart from all other peoples in the world. It has given us advantages so great that most minds fail to comprehend them. This heritage stems from a tradition and sensing of freedom which antedates by centuries the establishment of this Nation and the adopting of its written Constitution. Its tangible expression is embodied in the private enterprise system. The essential to its preservation is the sanctity of the human personality—the supremacy of the individual and the subordination of the state.

Yet, because the people do not fully understand this inheritance—because they are unable properly to appraise its worth—there is the prospect, or at least the possibility of its forfeiture. In a peculiar but very real sense, editors are the guardians of this priceless heritage of the American people. It is the privilege and the responsibility of the editors to explain its meaning and create an awareness of its vast yet incalculable value.

Politicians—possibly to extend tenure in office—have advanced proposals which would transfer to minions of the Federal Government the actual task of distributing medical care to 110,000,000 people. Such procedure would involve making the doctor subordinate to the bureaucrat. It would mean the regimentation of the medical profession—if it worked. Actually, no laws could regiment the doctors. They could refuse to serve under conditions which would result in mechanical and ineffectual service—personal subserviency and professional deterioration.

However, consummation of the plans inevitably would result in absolute regimentation of the people as far as medical care is concerned. They would be forced by law to accept such medical care as could be provided by the politically appointed bureaucrat.

Such a development could be a fatal step toward complete totalitarian control over the lives and destinies of all men. The people have a right to know. They should be told. Editors should tell them.—John M. Pratt.

## NO. 2 SOCIAL SECURITY

Deep depression, the hazards of war and limitless propaganda have made the American people "security conscious." Benefits which accrue under the existing social security laws generally are approved. Most people believe that the extension of benefits to more people is justified.

It is the function of editors to interpret for the people the meaning of the laws relating to social security. It is their responsibility to understand and explain to their readers the implications of proposed changes and extensions.

Under the existing social-security law, employment offices are maintained—under Federal and State control—to find jobs for the unemployed. Provisions are made for aid to the needy aged, the blind and for dependent children. Payments are made in cash.

To beneficiaries under the act, compensation is paid during periods of unemployment. Payments are made in cash. Retirement benefits, death benefits for surviving relatives, monthly allotments for widows and dependent children, are provided. The payments are made in cash.

Proposals have been advanced for the Government's providing full medical care and hospitalization for all social-security beneficiaries and their dependents. Authority is to be given a single Government official to hire doctors and establish rates of pay; to control and operate hospitals and actually dispense medical care to 110,000,000 people. No cash payments are involved. In effect, the Federal Government would establish 100,000 retail establishments, man them, and conduct the business of peddling pink pills to people.

Some people believe that in bureaucracy's vast pool of master minds there are individuals fully qualified to tell farmers what and how much they can sow and when and how to reap; other individuals competent to tell the oil wildcatter the size of the pipe and depth to which he is permitted to drill; and yet others with capacity to tell the newspaper editor what he can print and how he shall treat and headline his dispatches. It may be true.

No sane person can believe that any bureaucrat can direct the rendering of medical care without actual suicidal deterioration in the quality and effectiveness of the service that is provided. It is the ultimate in absurdities. The people should be told the facts. Editors should tell them.—John M. Pratt for the National Physicians Committee.

## NO. 3. THE SENTINEL ON THE WALL

For the American people the editor is the sentinel on the wall. They depend upon him to sound a warning when danger nears. Investing centralized government with unlimited powers always must be viewed with alarm. There is terrifying menace in proposals that have been made to transfer to Government the function of distributing medical care.

In the short span of 150 years American medicine has moved forward to a position of universally recognized world leadership. It has provided a more effective and a more widely and evenly distributed medical care than ever has been made available anywhere at

any time. If analyzed and understood, the achievement is without parallel in the history of the progress of mankind.

In the successful treatment and cure of disease medical care must be considered as having two separate yet closely related parts:

First: There is disease—disease as such. There are many diseases. Each disease is ceaselessly, relentlessly seeking a human body to destroy. And each disease affects each human body in a different way.

Second: There is the patient—a human being—who, by accident, misfortune, or coincidence, contracts a disease. American medicine has conquered many diseases—controls many others. However, the basic factor responsible for the unequalled effectiveness of the practicing physician is that the whole of his effort always is concentrated on treating and curing the patient—the human being who is sick. Incidentally only is he concerned with conquering the disease. The basic tenet of American medicine is that where there is a sick patient a life is the issue. It matters not whether prince or pauper is involved. The one concern is that of saving the human life which is in jeopardy. The task is exclusively a matter between the patient, the doctor, and their God.

The doctor is a human being, a person, a personality. His tradition, his knowledge, and his experience make him more sure and more confident than his fellowmen. Proposals advanced imply robbing him of his freedom of action and decision—making him subordinate to the bureaucrat. Bureaucratic direction would destroy the intangible, indefinable essence that is the secret of the American doctor's effectiveness.

It is the responsibility of American editors to investigate thoroughly and to understand fully the dangers inherent in Government assuming the task of distributing medical care in the United States. It is the duty of these "sentinels on the wall" to advise the people fully of the realities and the implications which are involved. Editors should tell them.—John M. Pratt for the National Physicians Committee.

#### NO. 4. CONGRATULATIONS TO ANPA

Since the very beginning of our Republic, newspapers have been recognized as the principal medium for the dissemination of information. They have performed a public service of inestimable value. They have been—and still are—a potent force in enlightening the people. Without a free and courageous press the progress that has placed the United States in a position unparalleled among the nations of the world could not have been achieved.

Americans have reason to be proud of the character and courage of the men who have guided the destinies of the public press through all these years. Editorial integrity and independence of thought have built a foundation upon which the confidence of the people rests securely. This public confidence imposes an added responsibility upon editors and publishers. It affords them a vast opportunity for public service. In times like the present, when the gravest of domestic problems and momentous issues with world-wide implications confront the people, the need for vigilance on the part of the press is imperative.

Foremost among the problems faced by the people of the United States is the terrifying trend toward collectivist control. In recent



years our constitutional processes have been challenged. Vast danger lurks in proposals that have been made to transfer to Government agencies tasks that have heretofore been recognized as a vital part of our free enterprise system. The most menacing of such proposals is embodied in measures now pending in Congress—for amendment of the Social Security Act—that would place the distribution of medical care in the United States under a Government bureaucrat. That the leaders of the American press are alert to this danger is evidenced in a report to the recent ANPA convention by its social-security committee. In a paragraph headed "Publishers should watch social-security legislation," the report says:

Your committee once more desires to urge upon every member newspaper to maintain an active interest in all of this type of legislation, as the many interests, including governmental agencies, labor organizations, and social groups are advocating so many different methods and applications of social security that we are developing some situations where it could conceivably be more profitable to be unemployed than it would be to work \* \* \*. Additional items such as sickness, hospitalization, and the like, are being urged vigorously and will be given consideration by many State legislatures as well as by Congress in the years immediately ahead.

The ANPA social-security committee is to be congratulated on forewarning editors against contemplated actions which would involve revolutionary changes in our methods of distributing medical service, lower the quality of medical care, and make practicing physicians subservient to politicians.

#### NO. 5. WAGNER BILL SEMANTICS

On May 24, Senator Wagner introduced in the United States Senate a new bill amending the Social Security Act. The bill, S. 1050, is a book-length document of 185 pages covering every phase of social insurance. It is presumed that none can take exception to any part of the proposals without being subject to the accusation of heartless opposition to providing the underprivileged with the benefits to which they are justly entitled.

American editors are the Nation's experts in the use of words. They are ever alert to safeguard the interests of the public. In a study of this document, these editors will be especially interested in the remarkable admixture of cold-steel intentions expressed with softening phrases and sheer preachment and propaganda disguised as integral parts of the proposed amendments.

The bill levies a direct tax of 8 percent on all wages and salaries of all workers in private employment up to \$3,600 of annual earnings, and a direct tax of 5 percent on the earnings of all self-employed people up to \$3,600 per year. It is estimated that this tax would produce each year a fund in excess of \$8,000,000,000. In all likelihood this is the largest amount resulting from any single tax levy ever made anywhere at any time. Yet, in all of the 185 pages of text, the term "tax" does not appear save with reference to refunds prior to 1946 and to make records conform to sections of the Internal Revenue Code—pages 168 and 172. The term "social security contribution"—page 164, is substituted for the unpopular term "tax."

Approximately \$3,142,000,000 of the total tax fund would be earmarked to provide personal health services. A National Advisory

Medical Policy Council is established—page 77. The Council is appointed by the Surgeon General of the Public Health Service. Its function is strictly advisory. It has authority to establish other advisory committees and commissions. But the Surgeon General is "authorized and directed to take all necessary and practical steps to arrange for personal health service benefits for all social security beneficiaries and their dependents"—page 72. These include general medical, special medical, general dental, special dental, home nursing, laboratory, and hospitalization benefits—page 100. The Surgeon General is established by law as the agent to dispense and pay for medical, dental, nursing, and hospitalization services for an estimated 110,000,000 people.

The bill states that the methods of administration shall insure the prompt and efficient care of individuals, promote personal relationships between physician and patient, provide incentives for professional advancement and encourage high standards in the quality of service—page 82. These are worthy objectives. They will be quoted endlessly by proponents of this legislation and by those who strive to establish centralized controls in the United States. They are nullified by direct proposals of the amendments. The sacred nature of the physician-patient relationship is destroyed by the introduction of an administrator and the public recording of symptoms and case histories. Professional standards are automatically and dangerously lowered when political favor takes the place of personal competence. The real incentive of the doctor is forfeited when he is made subordinate and subservient to the bureaucrat.

In the United States more than 50,000,000 people have provided for themselves measures of health protection through insurance with private carriers. When presenting his omnibus bill to the Senate, Mr. Wagner stated:

There has been much misunderstanding about the part that existing voluntary insurance or prepayment plans and similar agencies may play in the social insurance system. Let me emphasize that our bill makes a place for them to continue their good work.

But these are the facts. Participants in voluntary insurance plans or programs are exempted from the payment of the tax on that part of their earnings that is expended for the insurance premium—page 151. The tax to be paid by a worker earning \$3,600 per year would be \$144 annually. If a worker earning \$3,600 expends \$100 for any voluntary or group insurance program, he would pay the tax on \$3,500 of income or \$140. Under such circumstances private insurance programs could not survive.

In introducing his bill, Senator Wagner said: "But health insurance is not socialized medicine; it is not state medicine," and "I believe in the American system of free enterprise."

It is a fact, however, that under the proposals the Surgeon General of the Public Health Service, working under the Administrator of the Social Security Board, becomes the dispenser of all health care and the final arbiter of the mental and physical well being of the Nation. If such a core of collectivist control is ever established in this country applying to the most sacred and vital wants of every human being it would require a miracle for free enterprise in any of its forms to survive the impact.

These things the people should know. It is predicted that American editors will tell them.

(Political Semantics has been defined as the technique of pasting soothing-sirup labels on bottles of nitroglycerin.)

#### NO. 6. THE COLLECTIVE STATE

There are those in this country who sincerely believe that the welfare of human being can best be served through collectivist control.

Benito Mussolini believed it. He succeeded in persuading the Italian people that his belief was valid. The fruition brought neither contentment nor security.

Adolf Hitler believed it. Sixty million Germans accepted his philosophy. Today that which was the Reich is one vast panorama of desolation.

This belief is the cardinal tenet of the code of the Japanese Emperor. Tokyo, Yokohama, and Osaka have been leveled by flame.

We are a trusting people. In some respects we are gullible folk. It is essential in these times that we be ruthlessly realistic.

Communism, fascism, nazism are not mere matters of terms or definitions. They result from the establishment of centralized controls and the operation of mechanisms of administration. Unfortunately, in the development of these mechanisms the insidious step-by-step procedure may postpone recognition of their real significance.

There have been introduced in the United States Congress amendments to the Social Security Act. They are known as the Wagner-Murray-Dingell bills. Most Americans favor the expressed objectives of some of the proposals. However, almost hidden in the careful verbiage of the amendments is the cold steel move to place in the hands of appointees of the Federal Government sole and exclusive responsibility for the distribution of health care for 110,000,000 people. This service would consist of general medical, special medical, general dental, special dental, laboratory care, hospitalization, and home nursing service. In no country has machinery been established more sweeping in its provisions to serve the purpose of a collectivist state.

In the beginning the tax provisions would create a central fund of more than \$8,000,000,000 annually. It is not anticipated that this amount would even approximate the total cost. It is to be supplemented from general revenue. Alert editors have pointed out that our national debt is approaching \$300,000,000,000; that we are in the midst of a war only half won; that our economy could not sustain this additional drain of from 10 to 15 billion dollars each year.

The key principle of our freedom of enterprise system is more jobs for more men at maximum wages to provide ever greater markets for the products of a constantly expanding industry. Editors have drawn attention to the fact that the Wagner-Murray-Dingell proposals are a direct tax on employment. There would be a minimum of \$8,000,000,000 yearly less for consumers to spend for the potential output of our mines and factories and farms. This, of necessity, would create a downward spiral of production and fewer and fewer jobs for workmen. These results, within limits, would be inevitable.

They might be disastrous but they are not the really important consideration.

The unparalleled progress and incomparable achievements of the American people are the result of self-respect, individual initiative and self-reliance. When formalized security is substituted for self-reliance we forfeit the essence of the factor that has been our strength. When the incentive for individual effort and thrift is removed progress, as we have known it, will be shifted into reverse.

It may be possible that a truly wise and honest administration can reasonably ration the food supply of a nation. Save under truly totalitarian concept and control is it within reason to expect the effective rationing of physician and hospital services for 110,000,000 people. A vital difference should be kept in mind. If the food rationing fails, it may mean only that there are no steaks or pork chops on dining-room tables. If the doctor rationing fails, men and women and children die. Human lives are the issue.

The Wagner-Murray-Dingell health services proposals should be recognized for what they are. They are in reality state medicine. They are instrumentalities and mechanisms of the collectivist state. If we are to preserve our freedom-of-enterprise system we dare not enact these proposals into law. If the American people understand the facts and the implications, almost unanimously they will stand solidly in opposition.

In their final action on these amendments elected representatives will be influenced by what they believe to be the desires of their constituents. Editors can render an incomparable service by explaining the meaning of these proposals and encouraging readers to write to their Congressmen and Senators.—John M. Pratt, for the National Physicians Committee.

## VIII—ARTICLES BY DOCTORS IN FAVOR OF HEALTH INSURANCE

### A. AMERICA'S GREATEST OPPORTUNITY

(By Dr. Ernst P. Boas)

[Reprinted from the November, 1945 issue of Reader's Scope Magazine, New York 10, N. Y.]

Mankind is on the threshold of its greatest age of discovery. Power and machines and natural forces far beyond our most daring aspirations will soon be made the servants of man.

But what of man's advancement in the most obvious—but most precious—of all fields, the maintenance of life and health? Are we to remain backward? Or do we dare to take the first steps into the new future?

(Dr. Ernst P. Boas is chairman of the Physicians' Forum, assistant clinical professor of medicine at the College of Physicians and Surgeons, Columbia University, and associate physician at the Mount Sinai Hospital, New York City. During World War I, Dr. Boas was a captain in the Medical Corps and served as chief of medical services at Base Hospital No. 63, American Expeditionary Forces.)

A law to provide medical care for every one of the 135,000,000 people in the United States awaits passage by the Congress of the United States.

Senate bill 1050 aims "to provide for the national security, health, and public welfare." It has been variously called the Wagner-Murray-Dingell bill after its sponsors, the health insurance bill by its advocates and "a totalitarian blow to American liberties" by its foes.

We physicians have been fighting disease for centuries. Invincible as our enemy seems, we have never capitulated. We have made progress—in recent decades medical knowledge and methods have advanced rapidly through new laboratory techniques, specialization, and the use of powerful beneficent drugs.

Yet the American people participate only partially in the benefits of modern medical science. Millions who at this very moment need medical attention, neither can afford a doctor nor pay for treatments. Their minor ailments become chronic, and the chronically ill become a burden to themselves, their families, and to the community.

To correct this deplorable condition, Senate bill 1050 would expand medical and research facilities and make facilities for diagnosis and treatment available to everyone in the United States.

Under its provisions, every American—\$200 a-year share cropper to movie tycoon Louis B. Mayer—could afford the best medical service money can buy.

Senate bill 1050 brings the problems of the nation's health into correct perspective. It expands our existing social security law, which has been accepted as a small yet basic defense against old age and unemployment. It would broaden public assistance to the aged, blind, dependent children, and unemployables. It would permit the con-

tinued operation of the United States Employment Service to assist war workers, veterans, and other jobless, as well as farm workers, domestics, and others not covered by the present law. It would set up a national social-insurance system, increasing unemployment payments to cover temporary or extended disability, retirement pay, and payment to survivors in case of death.

But it is in the field of health that Senate bill 1050 offers something new in American life—the guaranty of the right of every citizen to the protection of medical science.

Upon passage of this bill, the social-security tax would rise from its present level to a flat 4 percent on incomes to \$3,600, with employers paying a like amount. (Three-fourths of the American people earn less than \$3,600 annually.) Only 3 percent or three-eighths of the tax would be applied to medical care.

A worker making \$3,600 a year would pay \$54 annually for health insurance. A worker earning \$1,000 a year would pay \$15. Self-employed professional men, shopkeepers, executives would pay a slightly larger amount.

This sum would guarantee not only ordinary medical care and hospitalization to the contributor and to his dependents, but also care by specialists, X-rays, laboratory tests, operations, etc.

Critics of Senate bill 1050 falsely charge that it would add \$4,000,000,000 annually to what the American people pay for medical care. This is flatly untrue. The American people now spend about \$4,000,000,000 a year for medical care. An average family of four in the middle income brackets now pays around \$120 a year for medical bills. But many families of small incomes pay but a few dollars a year and get little care. In about 5 percent of families, every year, some major illness costs hundreds of dollars and puts the family deeply in debt. Under the terms of the bill, all will prepay a small proportionate amount of their income while they are well, to take care of all illness when it occurs.

Senate bill 1050 would bring good medical care to this vast majority of Americans.

Like everyone else, Henry Ford would pay his annual health-insurance tax. Perhaps he would not make use of its advantages. He could, if he chose, protect his health as he pleased and as he could afford. George McDowell, 30, Ford plant electrician, who earns \$52.50 weekly, who has a wife and one child, would no longer need to dip into his reserves when sickness or accident affects him or his.

Mrs. McDowell is expecting a baby. George would pay nothing beyond his social-security payments for his wife's prenatal care, laboratory tests, specialists in obstetrics and pediatrics, or for postnatal care. Hospital bills up to \$7 a day would be paid by the Government from the general health-insurance fund for a period of 30 days and \$3.50 daily thereafter up to 120 days.

In the years to come the McDowells will frequently need medical advice. The children must be vaccinated against diphtheria, small-pox, typhoid; they will suffer typical children's diseases. Vincent may break his wrist skating on city pavements. Delicate Emily may require a special diet until she is three. Mrs. McDowell, hard-working housewife and mother, may be bothered by varicose veins. Intravenous injections might relieve her. Otherwise too costly, she would

obtain them automatically under the terms of the health-insurance bill.

When George first notices that the little letters in the telephone book wave before his eyes, he would visit an oculist and obtain a prescription—the oculist's fee would be paid by the insurance fund as well as the optician's charge for eyeglasses. When George suffers a touch of arthritis, progress of the disease would be averted and he would receive partial-disability insurance during his 3 weeks in bed. Afterward he could consult a specialist to learn whether the disease had affected his heart.

And similarly with Mrs. McDowell—as the children grow older and she approaches middle age, she may become depressed, sleepless, suffer from sweats, heart palpitations. With Senate bill 1050 a law of the land, she could visit a neuropsychiatrist who would ease for her the period of change of life.

In the deep South, Will Maxton, white sharecropper, and Jim Turner, Negro plantation hand, have worried through lives beset with the aftereffects of malnutrition, tuberculosis, pellagra, hookworm. Midwives have brought their children into the world. In emergencies, they have waited hours, sometimes days, for help.

Senate bill 1050 provides Federal grants to the States for the construction of hospitals and clinics. Doctors would hang out their shingles in the rural areas which up to now have been without a doctor's services. Why? First because they would be paid by the health-insurance fund for their work and thus be able to make a living in areas where they cannot earn a living under present conditions. Second, medicine today cannot be practiced effectively without hospital facilities. Both these handicaps would be overcome under Senate bill 1050. Will Maxton's and Jim Turner's family would have adequate medical care.

The Surgeon General of the United States would administer the health-insurance law. He would appoint, upon recommendation of leading medical authorities, a National Advisory Medical Policy Council, on which representatives of the public would sit with medical men.

The opponents of this legislation have raised the cry that the United States Surgeon General would become the medical dictator of the Nation. Nothing could be further from the truth. The bill specifically states that the Surgeon General must consult with the Advisory Medical Policy Council on every step in the health program. Further, the Council has the right to publish all of its decisions, bringing any disagreements to the attention of the general public.

Another false charge raised by the opponents of the bill is that the whole "show" would be run from Washington by a bunch of bureaucrats. Actually, all that the National Government would do would be to collect the money and set up minimum standards to be followed by all doctors and hospitals. Existing agencies within each State and local area, would supervise the application of the law. Where no such agencies exist, they would be created with the aid of national medical authorities.

Would—as enemies wildly charge—the quality of medical care deteriorate? No. Every doctor would have equal access to costly equipment, specialists' and consultants' services, laboratory tests. Every

patient would have equal access, regardless of his financial status, to the best medical science can offer.

In every community, the local agency would post lists of doctors who have agreed to practice under the plan. No patient would be forced to consult an approved doctor—no doctor would be forced to place his name on the public list. Complete freedom of choice would remain, as at present.

Doctors' average incomes would increase. They would be paid from the general fund either on a fee basis, by flat rate per capita, or by salary, as they preferred. In all cases, they would be paid.

When American youth responded to the selective-service law, a tragic wastage was exposed. Millions in the prime of life were ill with ailments which were immediately remediable or which might have been earlier checked, especially in childhood. It is to the credit of Senators Wagner and Murray and Representative Dingell that they have composed a measure which would help to correct this condition simply, democratically, and in accordance with approved medical standards.

The children of America, future defenders of democracy, will become stronger, abler citizens if Senate bill 1050 becomes law.

Because infectious diseases may now be more easily controlled, man's life span has increased in recent decades. Today, chronic degenerative diseases, cancer, heart trouble, diabetes, stand as the last barriers to longevity. With universal medical care through health insurance, these diseases may be discovered early, checked early.

Why, therefore, has Senate bill 1050 met with an unprecedented campaign of misrepresentation from such august organizations as the American Medical Association, the American Bar Association, the American Hospital Association?

Doctors, in most cases, are high individualists. Bound by their oath, they are proud of their responsibilities, yet jealous of their rights. Many, especially high-priced specialists, honestly believe that the health bill would enslave them to some vague bureaucracy. They fear that they will no longer be able to assess fees according to the patients' ability to pay. Others have unthinkingly swallowed the shibboleths of the American Medical Association, slogans which describe this bill as "communistic," "un-American."

Many millions of laymen have been similarly misled by the fantasies of such journalists as Paul Mallon, Benjamin de Casseres and other propagandists whose opposition is based not upon specific criticism but is part of a general counterattack against all progressive legislation.

To defeat Senate bill 1050 over \$1,000,000 has been raised in the past 3 years by the National Physicians' Committee. This committee is a front for the American Medical Association, which, because it enjoys tax exemption as an educational and scientific organization is barred from participation in political action. Much of this money has come from great pharmaceutical corporations and manufacturers of surgical appliances.

The spread between the manufacturing and retail costs of most life-giving drugs is unimaginably wide. Patients pay a minimum of \$1 for prescriptions which a New York City hospital compounds for an average of 31 cents.

Senate bill 1050, at this writing, makes no mention of drugs. But with its passage, the sick will obtain such products less frequently over



the counter, more frequently from their doctors in clinics or during hospitalization. Business for the pharmaceutical corporations will fall off—hence their interest in working to defeat the bill.

Our parents thought of a doctor as someone to be called in times of serious illness, after the usual home remedies had failed to cure. We are learning to think in terms of positive health. We want our doctors to keep us well, to guard us against the ravages of disease such as cancer, and we know that to enable them to do so we must be able to consult them freely before the disease process has become irreparable. We must give them the opportunity to employ in our behalf the complete resources of scientific medicine. As a nation we have learned the importance of good health of all our citizens, and are realizing that we cannot afford to leave the health of our people to the chance that they may have sufficient income to command modern medical care; or to expose them to the disadvantages that their race, their color, their occupation, or the residence in a less favored economic community may bring about.

America now has its greatest opportunity before it—the opportunity to safeguard and improve the national health. The time has come to marshal the complete resources of modern medicine and place them at the service of all of our people. It is for such a national health program that all of us, doctors and laymen, must work together. Our efforts are needed to give actuality to the plans that have been developed by competent experts.

#### IF THE HEALTH INSURANCE BILL BECOMES LAW

Question. Will I be able to choose my own doctor?

Answer. You may choose from all doctors participating in the insurance plan in your community.

Question. If I am dissatisfied with his services, may I change to another doctor?

Answer. Yes.

Question. Will I be able to go to my present doctor?

Answer. Yes; if he participates in the insurance plan.

Question. Will I be forced to visit a public-health office to engage a doctor?

Answer. No. He will visit you at your home or you may go to his office, exactly as you do now.

Question. How will I pay him?

Answer. You will not pay him directly but through an annual payment of your social-security tax, part of which will go into the health-insurance fund.

Question. How will he be paid?

Answer. Either by a fee scaled to your case, by a per capita flat fee, or by salary—as he chooses.

Question. How about specialists, operations?

Answer. The services of specialists and surgeons will also be provided for those who need them.

Question. What if I already have a chronic disease?

Answer. You will be at all times entitled to hospitalization for 30 days, with possible extension to 120 days.

Question. How about members of my family who do not pay the social-security tax? Will they be covered?

You—and all of us—would pay for this by pay-roll deductions of 1½ percent of your wages, with the employer paying a like sum. In this way you could afford complete medical care for yourself and every member of your family. The self-employed would pay into the fund, too, and the indigent would be covered by taxes.

I recognize with pleasure that labor helped to draft and is supporting the Wagner-Murray-Dingell bill. We doctors who approve the bill have made some suggestions for changes in it so that it will give the highest type of medical care to you, the consumers, and also guarantee the right of adequate medical education, intellectual freedom and economic security to us doctors.

We feel very strongly that such a system of national health insurance should be compulsory rather than voluntary. Voluntary schemes of health insurance have been with us for a long time. In fact, there are more than 200 such plans in effect now, enrolling 21,000,000 of the population, and new ones are springing up all over the country, raised as last-minute dikes by some frightened doctors and others against the encroaching tide of public action. The main objection to them is the very fact that they are voluntary.

Now, I am all for the individual and against regimentation, but there are times when even the individualist with the best of intentions needs a little prod. We would need a vast amount of education before the public would join in the numbers necessary—the majority of the population, remember—and ask to be enrolled in a scheme of health insurance. Many millions of persons who need health insurance—in fact, those who need it most—will never recognize that they need it or be able to afford it.

The main argument for compulsory health insurance is that nearly all existing voluntary systems give only limited service. The Blue Cross Hospital plans have been quite successful in reaching many people in many cities, but they only pay your hospital bill, not your doctor bill. In 12 years they have reached only 12 percent of the population. The voluntary plans generally accept for membership only those entering in a group. This usually excludes wives and children of workers. A few plans have experimented and have permitted everyone to join. This has usually been disastrous financially, for the poorest medical risks rush into such a plan.

Normally there must be at least 50 in a group. Thus, employees in small units, the self-employed and the farmers are not taken care of. Further, this type of insurance is expensive.

Some plans are sponsored by commercial-insurance companies that operate on the cash-indemnity system, whereby a flat payment of cash is made to cover certain specified payments. For instance, the company will pay you \$75 for an appendectomy, \$25 for the removal of tonsils, or \$50 for a fractured pelvis. But your doctor bill alone may exceed these sums, not to mention the weeks of hospital care that may run costs up hundreds of dollars more.

This sort of insurance puts the emphasis in the wrong place. It treats ills after they have occurred, rather than trying to prevent them before.

“With the growth in the powers of medicine to prevent and control disease,” says the report of the Health Program Conference, which is made up of eminent doctors, economists, and medical administrators,

"a program that mainly deals with serious or 'catastrophic' illness is insufficient medically and uneconomical financially."

These cash-indemnity plans are favored by the American Medical Association, however, because they preserve an illusion of the traditional method and because payment comes not from the State but from a private company, a large proportion of whose directors are often doctors.

Medical societies also sponsor health insurance plans that go further than cash indemnity. These usually provide insurance only to cover surgical or obstetrical cases in hospitals and the doctors must be paid on the usual fee-for-service basis. The Pepper committee report said of fee-for-service:

The pay-as-you-go or fee-for-service system, which is now the predominant method of payment for medical service, is not well suited to the needs of most people or to the widest possible distribution of high-quality medical care. It tends to keep people away from the doctor until illness has reached a stage where treatment is likely to be prolonged and medical bills large. It deters patients from seeking services which are sometimes essential, such as specialist care, X-ray, and laboratory examinations and hospitalization. Individuals with low incomes, whose need is greatest, are most likely to postpone or forego diagnosis and treatment.

Organized medicine has insisted on this fee-for-service principle which invites abuse when carried over into a health-insurance system. The best and most economical type of service can be given the ailing public by a group of doctors who work together instead of in separate offices. This is called group practice. The group should include general physicians and specialists in various fields, since the advance of medical knowledge makes it no longer possible for one physician to master more than a fraction of medical knowledge and skill. Moreover, modern equipment such as X-ray machines and other facilities costs too much for each individual physician to own.

Under the group-practice plan you, as a patient, would have the advantages of pooled knowledge, experience, and equipment. Doctors in the best group practices are paid on salary. They work like a well-organized hospital staff and they can supply good care at lower cost than solo doctors.

The enemies of compulsory insurance attack the Wagner-Murray-Dingell bill on many counts. Actually, the "compulsory" feature does not mean that everyone would be compelled to receive Government-ordered care. There will be no regimentation of either doctors or patients. There will always remain those patients who prefer to pay the private fees to one man rather than accept the services of another, just as there are private schools and public schools, and there will always be doctors who will cater to this type of practice.

We progressive doctors, along with other liberals and friends of the Wagner-Murray-Dingell bill, say:

The bill would not rob the patient of his right to choose his own doctor, but would extend that privilege to those who have never had it before.

Standards of care would be raised because a physician, working in a group in a hospital or health center, could make free use of costly equipment, specialists' services and laboratory tests, now often too expensive for patients to use.

Answer. Yes.

Question. Will I receive as good medical care as now?

Answer. Better, because your doctor will have access to all needed laboratory, specialist, and hospital services; and you will be able to afford any treatment he recommends without added cost.

## B. MEDICAL CARE FOR ALL<sup>1</sup>

(By Miles Atkinson, M. D.)

(Since the introduction of the first Wagner-Murray-Dingell bill in 1943, the Nation has been flooded with propaganda attacking the health provisions as "socialized medicine" and "regimentation." This propaganda purports to speak for the whole medical profession. There are a great many doctors, however, who, though they are themselves members of organized medicine, do not share this hostility. One of these is Dr. Miles Atkinson, one of New York City's leading doctors and a well-known writer on medical subjects. His views on health insurance are representative of those rapidly gaining support among liberal United States doctors who recognize that all is not well with our present methods of making health services available to the people who need them.)

The doctors of America realize increasingly, as do the men and women in the factories, on the farms, in the villages, and in the cities, that the health of the American people is not what it should be.

In the past we doctors and the public have boasted about our tremendous advancement in medical science, about the giant strides medicine has made in the last 75 years. Today we are forced to acknowledge that, in the very country with the finest doctors and hospitals and laboratories in the world, there is still far too much preventable illness. The draft rejections dramatized this fact for us. They shocked the conscience of the Nation.

We cannot maintain our equanimity, either, in the face of more than 100,000,000 cases of sickness occurring in this country every year, sickness causing a \$3,000,000,000 direct yearly wage loss, not to mention the toll in needless suffering and death.

We know now that the problem is largely one of finance, that a great deal of this illness is due to the inability of large sections of the public to pay for doctors and hospitals. The American Medical Association says that every family earning less than \$3,000 a year needs help in meeting the costs of serious illness. This is a staggering finding, for it really means that at least 75 percent of all Americans need such help.

The Nation's health has become a social problem. As one eminent doctor has said: "Because the doctor's services are purchasable and yet almost beyond price, they are coming to be regarded like life, liberty, and the pursuit of happiness—a civic right, a public necessity." And our late President Roosevelt included in his economic bill of rights "the right to adequate medical care and the opportunity to achieve and enjoy good health."

### WORKERS' UNMET MEDICAL NEEDS

We doctors recognize that you workers of America have vast unmet medical needs. We want to meet them, not only for your sake, but for our own sake as well. A method is needed to pay for those who cannot afford to buy good health, and to insure for doctors an adequate financial return.

<sup>1</sup> Reprinted from *American Federationist*, June 1945, vol. 52, No. 6.

The size of the investment in training a doctor is often forgotten. Doctors, too, must live, and they have to meet heavy expenses—under present conditions it costs 40 percent of a doctor's gross income to maintain his practice.

The young doctors in this country, even in boom times, often have a very hard time getting along. Some physicians do not like to admit this, but it is nevertheless true. They usually do a great deal of clinic work, also, for which they are not paid. All they do, if their private practice diminishes—because of patients' inability to pay—and their free clinic practice increases, is to stand agape and say, "Look what's happening to me!" When the Government comes along, however, with an offer to pay them for the work they now do for nothing, they draw themselves up with great dignity to announce, "I'll have none of this. My patients must come to me only on a private-practice basis."

This is a head-in-the-sand attitude which, unfortunately, is encouraged by the leaders of organized medicine. A group of progressive doctors have joined together, however, in an organization which we call the Physicians' Forum. We are members of organized medicine, but we disagree with the official policies of the A. M. A. in these matters. We stand with organized labor in actively supporting compulsory national health insurance as the only satisfactory way to distribute good medical care to all.

We all see cases every day where men and women needed medical attention long ago, but did not get it because they had not the money to pay for it and would not accept charity.

I am going to cite some of these cases.

There was a train engineer who thought he had indigestion, but put off getting the X-rays his doctor wanted because he was putting two sons through school and was perpetually short of cash.

By the time the pain became so severe that he couldn't bear it, stomach ulcers had developed and he had to have an operation that cost him \$200 plus weeks of hospital care and lost wages. If his difficulty had been diagnosed in time, good care might have saved him all this pain and expense.

There was a housewife whose seemingly slight cold was neglected until she was in bed with pneumonia. It took weeks of expensive doctoring and nursing to put her back on her feet. Fortunately, she had hospital insurance, so that phase of her care was prepaid.

Think how wonderful if she and the engineer had belonged to a comprehensive medical plan such as would be set up under a system of national health insurance! Each would have called the doctor earlier, each might have received preventive care rather than have waited until they were seriously ill.

That is why the Physicians' Forum believes the Wagner-Murray-Dingell bill<sup>2</sup> now pending in Congress is an approach to solving the problem. By its provisions Americans would receive comprehensive medical care from birth to death.

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<sup>2</sup> The Wagner-Murray-Dingell bill (S. 1050 and H. R. 3293) was introduced in the Seventy-ninth Congress on May 24. This improved bill takes the place of the old Wagner-Murray-Dingell bill which expired with the Seventy-eighth Congress. It was prepared by the sponsors in consultation with President Green and the A. F. of L.'s committee on social security.

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The bill would not rob the patient of his right to choose his own doctor, but would extend that privilege to those who have never had it before.

Standards of care would be raised because a physician, working in a group in a hospital or health center, could make free use of costly equipment, specialists' services and laboratory tests, now often too expensive for patients to use.

Doctors would be as independent as now, except that they would be sure of getting paid.

Most doctors' incomes would be raised (certainly the half of all United States doctors who earn less than \$3,000 annually would benefit).

The many persons who now have no care at all would receive it.

This method would not violate any of our American traditions, since the Government already helps pay the medical bills of many impoverished people, and the local and State health departments and the United States Public Health Service look out for the health of all of us in certain particulars.

Medical fees could be kept as stable as in the past, with the net income of the profession increased through the increased consumption of medical care.

Very little "new" money would be called for, since the American people already spend between three and four billion dollars on medical care and the latter sum is what would be spent under the Wagner-Murray-Dingell plan.

Passage of a national health insurance bill would not destroy voluntary plans meeting good standards—many would continue.

Along with the Wagner-Murray-Dingell bill there is a hospital construction bill which we favor because it would provide hospitals and health centers in all those sections that are now so pitifully devoid of them—especially the rural sections where it is a commonplace for sick people to travel from twenty-five to a hundred miles to visit a doctor or a hospital. If these hospitals are built they will help to draw some of the 20,000 young doctors returning from the war to the areas that need them so badly. The doctors would be glad to go where they are sure of a livelihood and of the opportunity of taking their patients to fine modern hospitals, of using the laboratories and of consulting with other doctors on the hospital staffs.

We progressive doctors believe, along with organized labor, that a bill of the nature of the Wagner-Murray-Dingell bill should be passed as quickly as possible by the Congress. We hope that organized labor will be active in pushing it, and we ourselves will do all we can to make our voices heard.

### C. THE MEDICAL PROFESSION'S REACTION TO COMPULSORY HEALTH INSURANCE<sup>1</sup>

(By Dr. Allan M. Butler, member, Committee of Physicians for the Improvement of Medical Care, Inc., and associate professor of pediatrics, Harvard Medical School)

In a letter that reached me December 31, Mr. Schmidt wrote:

You might discuss the problem of providing adequate medical care for the people of the United States, giving the background of the problem; the adequacy of medical men; the distribution and availability of hospital and clinical facilities in terms of various groups; and special problems, in order to give the audience, which will be composed of intelligent laymen, a picture of what the medical problem in this country really is. As I view the problem, I am driven to the conclusion that compulsory health insurance is only one phase of a much bigger and over-all problem.

<sup>1</sup> Reprinted from Social Security in America, addresses before National Conference on Social Security, sponsored by Chamber of Commerce of United States of America, Washington, D. C., January 1944.



Mr. Schmidt's point of view is in agreement with that of the Committee of Physicians for the Improvement of Medical Care. This committee, in presenting in 1937 certain principles and proposals concerning the provision of medical care, not only began with the principle "the health of the people is a direct concern of the Government," but ended with the statement "the subscribers to the above principles and proposals hold the view that health insurance alone does not offer a satisfactory solution."

In an attempt to conform to Mr. Schmidt's suggestions, my remarks will deal with three aspects of the problem: First, the background; second, certain considerations pertaining to compulsory health insurance in a national health program such as the Wagner-Murray-Dingell bill; and, third, the public's reaction to such a national health program.

### I. THE BACKGROUND

Medicine is only one of the many fields of science in which advances in technology have outstripped the application to social needs. These inadequacies are reflected by popular interest in bettering medical care and by the fact that you have devoted an afternoon to the discussion of health insurance. Inadequacies in medical care, of course, exist. The problem has been objectively presented in the report of the Committee on the Costs of Medical Care, 1932; the two-volume study, *American Medicine: Expert Testimony Out of Court*, 1937; the report of the California Medical Economic Survey of 1938 by Dodd and Penrose (not the abbreviated report published by the California Medical Society, in which the conclusions and summary were omitted); the report of the National Health Conference in 1938; and the recent findings concerning the health and medical care of draftees. A frank recognition of these shortcomings in our present medical care and a tolerant discussion of means of correcting them is a primary prerequisite to evolving means of providing better medical care in a democracy.

Most students of medical care recognize that the present-day organization or rather lack of organization of our medical services is to a considerable extent responsible for the gap between our actual and possible accomplishment.

From an operation standpoint, the individualistic practice of medicine entails an inefficient utilization of doctors and facilities and, thus, a wastefulness that must be shocking to businessmen. Young physicians at their most vigorous time of life sit idle in their offices waiting for patients that do not come, when many individuals are being seen hurriedly in crowded clinics or by older, less vigorous doctors. The partial use of expensive facilities in individual offices adds the cost of idle and reduplicated equipment.

In this day of expensive medicine, it is a widely accepted premise that the average patient should not be expected to meet the costs of serious illness at the time they are incurred. Yet, the present fee-for-service system of payment expects and demands just that. In so doing, it limits the individual or private support of medical care and places an unnecessary burden of charity on government and private hospitals and doctors. To compensate for this charity work, physicians demand the right to make arbitrary charges with meager knowledge concerning their propriety and with a totally inadequate means of distributing these social collections to the doctors according to the

actual charity services rendered. Moreover, hospitals are deprived of an income that might be used to pay the young doctors who now render service to the public without adequate remuneration. Since everyone needs medical attention at many times during his life, a logical budgeting for illness would be accomplished by applying the principle of insurance cost-sharing as widely as possible. Even with an adequate distribution of costs and an efficient organization of medical services, the quality of medicine that can be attained probably will be limited by what society can afford to pay. But so long as good medicine continues to reduce the costs of illness to society, even if it increases the cost per sick individual, what is an impossible extravagance for the individual may become a realizable economy to the Nation. No data at hand suggest that application of this principle to medical costs is per se either economically unsound or detrimental to the quality of medicine. Yet in the United States its application in an economical manner has met with considerable opposition.

Insurance for hospital care was well under way in 1932. Prepayment medical groups sprang up here and there. The house of delegates of the American Medical Association in 1933 did not approve the majority report of the Committee on the Costs of Medical Care which recommended that medical service be furnished largely by groups of physicians organized preferably around hospitals and that cost of medical care be placed on a group payment basis. In 1934 the house of delegates adopted 10 fundamental principles. One deserves mention here:

Sixth: However the cost of medical service must be distributed, the immediate cost should be borne by the patient, if able to pay, at the time the service is rendered.

The American Medical Association opposed Blue Cross hospital insurance as late as 1934.

In the same year the judicial council of the American Medical Association reprimanded the American College of Surgeons for promulgating a prepayment plan for medical care at approved hospitals.

The expulsion of Drs. Ross and Loos from the Los Angeles County Medical Association and the California Medical Association because of their operation of a group prepayment medical service is one of several such instances that might be mentioned. Subsequent investigation in 1938 revealed that:

The appellants were brought to trial with no definite knowledge of what they were charged; they had no adequate opportunity to defend themselves; they were expelled for some unknown act not appearing in the charges and they did not have a fair trial. (J. Amer. Med. Assn., 1936, 106: 801.)

The Journal of the American Medical Association (1938, 110: 230B), in commenting on medical problems in California, stated:

There are continuous efforts to induce county medical societies to organize prepayment medical service groups, but so far these have been successfully discouraged.

The house of delegates of the American Medical Association, in June 1938, reiterated its ten fundamental principles of 1934, adding the following:

That the American Medical Association adopt the principle that in any place or arrangement for the provision of medical services the benefits shall be paid in cash directly to the individual member. Thus, all direct control of medical services may be avoided.

Then came the National Health Conference, followed by a special meeting of the house of delegates of the American Medical Association which approved in principle tax-supported medicine for the indigent and voluntary self-supporting prepayment schemes. But the policy of not permitting control over economy and quality of service remained unaltered. Moreover, the means by which a distribution of the costs of medical care incurred by the intermediate low-income groups, who are neither indigent nor financially able to pay the costs of voluntary schemes, was left for future consideration. This is the very group which reports from the American Medical Association's recent survey of medical care show is receiving inadequate medical service. Surely the individuals of this group should not receive care as indigents. If they do, the number of individuals in this and the indigent group would approximate 75,000,000. They should and can assume a portion of the costs, but they cannot afford most of the voluntary schemes that provide complete medical care of a proper quality.

The rapid increase in medical knowledge and facilities has created a pressing need for an organization of medical service in the interest of economy and efficiency. A sound approach to the problem is provided by the recognition of the validity of two statements which appear paradoxical when considered superficially. First, medical knowledge and science have grown beyond the capacity of the individual physician. Second, 80 percent of illness may be cared for properly by the general practitioner. On the one hand, there is the recognized specialist trained to apply special knowledge and technique to the diagnosis and treatment of disease; on the other hand, there is the family practitioner who cares for the many illnesses that do not demand special technical knowledge and facilities, but, nonetheless, require a high quality of clinical experience and ability. It is as inefficient to have the highly skilled specialist caring for minor illnesses as to have the family practitioner treating illness that demands knowledge and techniques with which he is not thoroughly familiar.

Attempts to organize medical services must include all aspects of its science, its art, personal relations, techniques, and physical equipment. The inclusion of all these makes the problem of organization difficult. But it need not follow that regimentation is implicit in organization, nor that the family physician will be discarded. He should still care for the 80 percent of illness for which he is the specialist and by his skill recognize the 20 percent that is best handled by other specialists.

There is a natural and increasing tendency for the recognized specialist to become associated with large clinics. This is probably as it should be. It favors their continued education as well as the economic utilization of assistants and modern expensive equipment. There should be no antagonism between these specialists of the large clinics and the family practitioners. The services of the one supplement those of the other in fields so vast that neither alone is adequate. The former make available to the practitioner diagnostic services and special treatment. They introduce new methods of medical and surgical diagnosis and therapy. They staff teaching clinics, publish results of their special investigations, speak before medical societies, and thus give gratuitously to the general practitioner the new medical knowledge that each succeeding year becomes his stock in

trade. On the other hand, many practitioners give much of their time to the clinics, thus providing them with the experience that they alone possess. The mutual dependence of these two groups of physicians is evident. Yet there is a lack of appreciation of their respective roles.

Qualifying professional boards have classified the well-qualified specialists of urban communities by certification as specialists in particular fields of medicine. In spite of this, the fact remains that most laymen have great difficulty in distinguishing between the qualified and the unqualified specialist. Yet during the past few months representatives of the American Medical Association in considering the emergency maternal and infant care program have opposed recognition of a distinction between the provision of ordinary obstetric and pediatric care by physicians possessing professional qualifications as specialists in obstetrics and pediatrics and by physicians having no such special professional qualifications. At the same time, these representatives have advocated that payments under this program be made as cash payments to mothers, not physicians. Thus, once again, they are violating the fundamental principle that the collection and disbursement of large sums of other people's moneys must be supplemented with a responsibility for their prudent and economical use. This responsibility obviously is removed if all control over the effectiveness of the expenditures is denied.

Moreover, in spite of the ardent advocacy of free choice of physician by the American Medical Association and its constituent State societies, the representatives of several State societies wish under this program to restrict free choice to individual private practitioner care by denying mothers the right to freely seek medical care from organized medical groups, such as clinics or hospitals, that are well suited to provide a high quality of service economically. Equally informative of the medical profession's attitude is the fact that 420 doctors in Maryland, for example, are caring for patients under the program as voted by Congress in spite of the opposition of the so-called representatives of organized medicine.

The so-called organized medical profession still limits even voluntary prepayment schemes to rather circumscribed patterns, which much evidence suggests do not meet the needs of economy and high standards. Within the past few years it has opposed the development of Group Health Association, Washington, D. C., in a manner that was judged by the Supreme Court of the United States to be contrary to our accepted laws of free enterprise. It opposed the White Cross Health Service of Boston and, as you know, it more recently has opposed the development of the Kaiser Health Service on the west coast.

Why does the medical profession appear to be opposed to insurance-financed integrated group practice? A logical explanation might be the following:

First, as indicated even by this brief review, the societies representing organized medicine do not permit the expression of a minority opinion. The majority opinion is considered the unanimous opinion. The book *The Political Life of the American Medical Association* by Garceau, Harvard University Press, 1941, explains the manner of accomplishing this without openly transgressing democratic principles. Unfortunately, this restriction of minority opinion inhibits

considered discussion and the development of sound progressive thought. Hence organized medicine is notoriously reactionary.

Second, most of the other medical societies are composed, for the most part, of the physicians who are working in clinics, hospitals, research, and teaching institutions. They are concerned almost wholly with clinical and scientific medicine and are not concerned with the economic or organizational aspects of medicine. Therefore, their journals provide no means for expressing opinions regarding these latter matters. As a minority group in the societies of organized practitioners, this group of doctors is permitted no opportunity to express publicly its opinions through the channels of organized medicine. This statement does not apply to hospital and public health association journals, which have been far more liberal in presenting various points of view.

Third, insofar as the American Medical Association and its constituent State and county societies are composed largely of individualistic fee-for-service practitioners, they may both naturally and honestly oppose a development of medical services that changes their system. An example of the attempt of representatives of such societies to suppress discussion and inhibit activities by physicians is furnished by the proposal in 1938 of the council of the New York State Medical Society to amend the bylaws as follows:

The component county medical societies, their officers, committeemen, and members shall not initiate any policy, propose any legislation or participate in any activities that are contrary to the policies of the Medical Society of the State of New York.

Fortunately, this was so objectionable to liberal members and to the inherent individualism of many physicians that the amendment was not accepted.

Thus a possible explanation is that the official attitude of organized medicine derives from a greater interest in perpetuating a time-honored system of medical practice than in providing better and more economical medical care.

But whatever the explanation, it should be remembered that it does not necessarily reflect the considered opinion of all doctors. Whether it reflects the best interests of the majority of the consumers of medical care or even of the medical profession remains to be seen.

It can hardly reflect concern for quality and economy of medical care, for it opposes the very type of insurance service best suited to such ends. Those of you who are familiar with the clinic, hospital, social service, nursing, and occupational therapy services associated with such institutions as the Johns Hopkins Hospital can readily conceive the exemplary and economical care that could be provided under an integrated insurance medical service operated by such a hospital and its staff. At long last the majority of patients receiving medical care from such a hospital would not be classed as indigent and the physicians providing the care would receive the compensation deserved. The needed extension of hospital service to home care could be accomplished without treading on the toes of private practitioners. Certainly the time is long overdue for the voluntary development of such services. And it is imperative to economy and the preservation of high standards of teaching and practice and to the advancement of medical knowledge that any national health program provide for the development and full utilization of such integrated hospital services.

## II. CERTAIN CONSIDERATIONS PERTAINING TO COMPULSORY HEALTH INSURANCE IN A NATIONAL HEALTH PROGRAM

Recently the Committee of Physicians for the Improvement of Medical Care in its summary and analysis of the Wagner-Murray-Dingell bill stated:

The committee has already recorded its approval of a national health program. It believes that some very definite legislation is necessary to make better medical care available to individuals of average income and to the indigent. It, therefore, believes that the medical features of the Wagner-Murray-Dingell bill deserve thorough consideration and constructive criticism. However, the committee does not approve the bill as it now stands without definite and important changes which will further the economy and efficiency of the administration of the bill and of the service rendered under it.

The statement, which I shall quote freely, then discusses various parts of the bill.

That economy demands Federal collection of funds seems almost self-evident. Collection by States under various schemes and systems of records would create a confusion incident to change of residence alone that would be uneconomical. Though the committee appreciates that direct contributory insurance favors a desirable public awareness of the cost of medical care, the committee is of the opinion that a tax-supported system may be more equitable and more economical.

Moreover, under such a tax-supported system it would be possible to develop a program logically to provide care, first, for those who lack it most, the truly needy, expanding it progressively to cover the whole population, either according to a prearranged time schedule or as experience warranted its extension.

If economy demands that the collection and distribution of funds be at the Federal level, then the broad "principles which shall govern the use of these funds must also be established at the Federal level" in order to define the responsibility for the prudent expenditure of funds with a clarity conducive to economy. Equally essential to efficient and economic operation of a national-health program is decentralized control of operational aspects of the health services. The organization of medical practice should vary with the density and wealth of the population and with other factors.

Medical care cannot be bought and distributed like a commodity; it is a service involving a mutual personal relationship between doctor and patient; between one doctor and another and between doctors and members of other professions involved in hospital and other aspects of medical care. For all these and other reasons and because it will foster variety of experiments in procedure and health emulation, the program, though centrally controlled, should be, as far as possible, locally administered with its integral parts subject to modification and control by the communities in which they are situated.

The Surgeon General of the Public Health Service appears to be the logical responsible administrative officer. Provisions in the Wagner-Murray-Dingell bill for a National Advisory Medical and Hospital Council are highly commendable.

Great care should be taken lest the Council consist only of representatives of large organized groups, concerned chiefly with furthering their own particular purposes.

To endow the Council only with advisory powers and to grant its members moderate remuneration only for the time spent in the conduct of their duties will tend to remove membership from the political arena. On the other hand, unless certain additional provisions are incorporated in the bill, the Council may be reduced to impotence. It should be made mandatory upon the Surgeon

General and the Social Security Board to refer all matters of policy to their respective councils for study and advice before action can be taken. Provision should also be made for publication of decisions, recommendations, surveys, and studies made by the Council. This would lend more force to their recommendations and would tend to prevent the authorities from disregarding them without cogent reasons.

Of the validity of the actuarial statistics upon which the financial estimates are based, the committee is not competent to judge. The editorial columns of the Journal of the American Medical Association and its propaganda agency, masquerading under the name of the National Physicians Committee for the Extension of Medical Care, has made much of the magnitude of the figures involved. Dr. Nathaniel W. Paxon, director of the Massachusetts General Hospital and a past president of the American Hospital Association, in a recent analysis of the bill, expressed the opinion that the financial estimates seemed reasonable. Careful study will reveal, I believe, that they are not excessive. You as businessmen know something of the cost of absenteeism incurred or prolonged by lack of adequate medical care. Either fortunately or unfortunately, more and better medicine should result in an economy to the Nation, though the cost on superficial inspection appears large. The last thing we want is cheap Government medicine, for the bill would still be large and the economy in national health nil.

Available experience shows that current individualistic fee-for-service medical practice and insurance or tax-supported medicine are incompatible. It is one thing to have a patient pay a doctor for each visit or service rendered and a far different thing to have a third party make the payment. Where the patient pays or is under obligation, there is an automatic check on unnecessary and extravagant medicine. Where a third party pays, there is the opportunity of malingering on the part of patients and of prolonging or exaggerating treatment on the part of physicians.

Although the majority of physicians and patients would not take advantage of this situation, it is a mistake to institute a system that puts a premium upon chicanery and connivance. Fee-for-service payment under a system of public medical care places unscrupulous patients and physicians at an advantage, and forces the decent members of both groups to assume the unpleasant role of censors. It is significant that in England, under the system of national health insurance, physicians have expressed their preference for per capita payment rather than fee-for-service.

The fee-for-service system is particularly objectionable when combined with the provision now in the Wagner-Murray-Dingell bill that the majority of general medical practitioners in each area shall elect the method of payment. This might mean that in an area in which the majority did elect fee-for-service payments, the formation or continuation of group organizations might be impossible. Teaching hospitals and other institutions with salaried staffs could not participate in the plan. As many such institutions are the major contributors to teaching, maintenance of high standards, and the introduction of new methods of treatment, limitation of their use and support would be a serious catastrophe to American medicine.

The bill states:

The methods of administration, including the methods of making payments to practitioners, shall \* \* \* provide \* \* \* coordination among the services furnished by practitioners, hospitals, health centers, education, research, and other institutions, and between preventive and curative services. \* \* \*

This becomes little more than a pious hope if measures, such as fees for services, which are inconsistent with such a coordination, are authorized.

The incompatibility of individualistic fee-for-service practice and economical and efficient insurance of tax-supported medicine has long been recognized by the American Medical Association. Its desire to defend the former explains its opposition to the latter. Now that it has accepted insurance medicine in principle, it is protecting the fee for individual physician service by ignoring the incompatibility. State medical societies are setting up various voluntary insurance schemes under which insurance premiums or subscription rates are to pay the costs of individualistic fee-for-service medicine without any adequate control over economy or quality of service. Under these schemes, if the subscription rates are to be kept at a price the public can afford, fees will have to be slashed or services curtailed. In either case, the quality of medical care will deteriorate.

There should be concern about the expenditures under the bill of capital funds for hospital construction; for example, for the construction of hospital laboratories. There is no doubt as to the importance and need of improvement in such facilities. The major need, however, is not the building of laboratories for all community hospitals but the proper development of comprehensive laboratories at selected medical centers to which patients who need highly specialized examinations will be referred by surrounding community hospitals and physicians. An appreciation of the proper role of such laboratories is particularly important in relation to a national health program. Without it, large sums of money may be wasted in a "pork barrel" fashion for the construction of laboratory facilities throughout the country that may then go unused or misused for years.

The Wagner-Murray-Dingell bill needs the modifications indicated to protect the public against wasteful expenditures, to defend a high quality of medical care, and to permit the provision of better health to the majority of the people. It should be given considered thought and constructive criticism.

If a national health bill is to be written at all, it should be one that has some chance of attaining the desired ends, not one in which compromise at the inception has defeated them. The lack of coordination, efficiency, and economy that is inherent in our present individualistic medical practice and many of the State-wide insurance schemes must not be carried into Government medicine. To argue that it should, because the medicine we have today is better than that which we have had, is irrelevant. In considering a national health program, we are concerned with the quality and cost of the medicine we shall have as the result of legislative enactment. The pertinent questions are: Must a system of providing medical care be used, which will make that care more costly and more inefficient than it is today? Or, faced with the reality that Government medicine is at hand, shall we insist that it be provided economically and efficiently? If we do, health and solvency may be had. One thing is certain—the one cannot be had without the other.



## III. WHAT IS THE PUBLIC'S REACTION TO A NATIONAL HEALTH PROGRAM?

Instead of participating in tolerant consideration and constructive criticism, some organizations are appealing to emotion and prejudice by raising the Hitlerian cry that the evils of communism are about to destroy the standards and quality of American medicine because insurance medicine under the supervision of our democratic government may limit our private individualistic fee-for-service practice.

The propaganda implies that the fee-for-service system has made our medicine what it is today. What are the facts? The research that has led to new medical knowledge has been accomplished for the most part by individuals working on a salary basis in university, foundation, and government laboratories. New knowledge has been introduced to medical practice by the doctors employed in the large city, county, State, or large private charity or noncharity hospitals. Most of the advances in preventive and social medicine represent the accomplishments of State and Federal departments of health.

The same propaganda charges that the essential personal relation between doctor and patient depends on the perpetuation of private individualistic fee-for-service medicine. To be sure, in the United States this has to some extent been true. But why? Not because this type of practice particularly favors this relationship; but rather because the restrictions placed on clinic and hospital medical services have given very little opportunity for the development of such a relationship. As already indicated, there is no valid reason, other than the opposition of physicians, why these limitations should continue.

Many Americans react violently to bringing the Federal Government into a national health program. They do so though the Federal collection of the insurance funds is in the interest of economy; though Federal control of broad policies is in the interest of efficiency and high standards; and though administration of services is to be decentralized and at the local level. It is odd that in spite of the fact that we boast of our representative government, we unhesitatingly refer to it as corrupt and incompetent. In fact, it is believed to be so dishonest and inefficient that an important political concept is that our Government should be as ineffectual as possible so that it will do as little as possible. No wonder the totalitarian states thought little of our ability to function on a national scale. And yet our National Government faced with the present emergency has directed our war effort with extraordinary ability.

Not only does this bill entail "government" but also "compulsion." People in this country of a free government react to that with equal volency. One may well be puzzled by what is voluntary and what is compulsory under a representative democracy.

We yearly experience the trials incident to the successful raising of the prescribed community chests. Solicitors call on us in our offices and in our homes. Names of individuals with the amounts donated are published. Probably the adequacy of your and my contributions are commented upon at teas and luncheons. We all agree that our donations fall under the category of "voluntary."

Our freely elected Congress and President years ago enacted an income-tax law. Yearly we comply according to the specific rates applied. Is that compulsory or voluntary? Is it totalitarianism or an example of the smooth functioning of democracy?

Our same freely elected representatives after public discussion may extend the existing social-security laws to provide for all persons, access to, but not compulsory use of, essential medical and hospital services according to their medical needs. Is that autocratic compulsion or an expression of the free will of the majority in a democratic society? Is that un-American or as American as our democratic system of education, where both support and use of service entail compulsion?

These questions deserve tolerant consideration. For the health and suffering of the people of the United States and the cost of their medical care are a direct concern of our Government and a reflection of the character of our democracy.

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### C. MEDICAL CARE PROBLEMS<sup>1</sup>

Basil C. MacLenn, M. D., director, Strong Memorial Hospital, Rochester, N. Y.

There may be some in this audience who deny or decry the presence of problems in medical care. There are others here, however, who know at first hand that in spite of the scientific advances of American medicine during the past 50 years and in spite of a relatively high standard of living in this country, there are many blind spots of supply and many barriers to adequate medical care. I shall not try to write all of the Lord's Prayer on the head of a pin, but briefly let me summarize what I believe are some of the main obstacles. They are problems of quantity, of quality, of ignorance and apathy and of money.

The current Nation-wide shortage of physicians, dentists, and nurses is due mainly to service in the armed forces of a large proportion of these professional personnel. But, in addition, much of the current shortage is due to an increased demand for needed service by civilians who suffer also from the paradox of war prosperity. The same may be said of the shortage of hospital and related facilities. In certain localities there are critical shortages because war industry has swollen the local lists. Yet community after community which has had little, if any, increase in population reports an unprecedented demand for hospital care. This demand undoubtedly reflects increased income, the growth of prepayment plans for hospital care, plus the continuance of a long-time trend toward greater use of hospitals.

It is believed that the demand for more and better medical service will continue in war and in peace. Many thousands more public health nurses are needed now. For medical care, it is predicted that more physicians will be needed or that more efficient distribution must be obtained. A poll of medical officers in the armed forces indicates that most of them would prefer to practice in groups and I believe that many of them will wish also to continue to have the advantage of

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<sup>1</sup> Reprinted from *Health Insurance in America*, Chamber of Commerce of the United States, 1945, pp. 26-31.

salaried practice. Millions of men and women in the armed forces have learned the benefits of group practice and have received good medical and hospital care with no "fee for service." The Committee on the Costs of Medical Care, under the chairmanship of Ray Lyman Wilbur, recommended group practice in their report of 13 years ago and although the Journal of the American Medical Association branded it then as "socialism and communism inciting to revolution," group practice has now belatedly received a nod of official approval.

Hospitals, like doctors, are unevenly distributed. Doctors and hospitals are located generally in direct relation to the financial resources of the people. The more prosperous communities are relatively well supplied. The poorer areas with greater needs are lacking in doctors and hospitals. Many areas will need new hospitals—many will require additions to existing hospitals. And here I digress to hope that the new hospitals of the next decade will be designed for efficiency of function rather than extravagance of form. One of the barriers to medical practice in a rural area is overcome when a hospital is built. A modern doctor needs more than a black bag and penicillin.

Few would dispute that the quality of medical care received by the people of this country is variable. In buying most things, the individual's experience and common sense usually enables him to judge the quality of the product but witness the number of people who patronize chiropractors, naturopaths, and all the other types of charlatans and witch doctors. Among licensed physicians it is difficult for the public to tell who is competent and who is not. Medical licensure is no guaranty of professional skill for it is based only on a prescribed course of study and examination. Once licensed, a doctor is always licensed unless convicted of some extremely antisocial act.

The medical profession has assumed the responsibility of policing its own members. Now medical societies are a power for good professional conduct, but it is extremely difficult to judge the extent of their influence. In this country the penalties for misconduct are light. When they are imposed, which is seldom, it is as often as not for conduct deemed bad for the medical society as an organization, as for conduct prejudicial to the interests of the patient. Further, a substantial number of physicians, possibly those most in need of regulation, do not belong to medical societies and are thus beyond their jurisdiction. Membership in a medical society, like licensure, therefore, is no guaranty of competence. The State and the medical society assume that the physician is as competent 35 or 40 years later as he was at the time he was licensed. In New York State, for example, the recognition of specialists is in a state of confusion. Where the expenditure of public funds is concerned, a physician may, as in workmen's compensation, be considered competent in a special field if so judged by a committee of his county medical society. To render special service for another governmental agency, he may be required to be approved by a national, nonofficial board of physicians. Or the governmental administrator may have the power to accept a physician as a specialist on rather elastic grounds, depending upon general reputation and local circumstances as guides. Where public funds are not involved, the patient as a rule must rely upon the judgment of the physician who refers him to another physician for specialized treatment.

Affiliation with a recognized hospital is perhaps the best assurance to the patient that the care he receives will be of good quality. Unfortunately, not all physicians—only 4,500 out of 18,000 in New York City, for example—have connections with recognized hospitals, but it is certainly not implied that all the others are incompetent. Service on the staff of a good hospital, however, offers the physician opportunity to study and use modern diagnostic and curative facilities, provides stimulating contacts with physicians in the same or other fields, permits joint discussion and study of current developments in medicine and, through clinical and pathological conferences, enables evaluation of the methods employed. In other words, the voluntary hospital system provides continuous postgraduate education for staff physicians. Attempts to furnish the equivalent for nonstaff members have for the most part consisted of articles in medical journals and lectures and addresses at medical-society meetings and special institutes under the sponsorship of the medical societies, sometimes with aid from State health departments. The results are often disappointing because physicians most in need of instruction frequently fail to attend. One method proposed to insure continued professional competence is to require physicians to take examinations at intervals of, say, 5 years. Failure would necessitate further study before the physician could be licensed for an additional period. This proposal seems rather extreme, and it is doubtful if it would ever be adopted. Another proposal is to provide and require periodical resident postgraduate education at public expense, as obtains in some educational systems.

A system of regionalization of hospitals offers perhaps the best hope for improvement of quality. The gearing together of the facilities for diagnosis and treatment of the large medical centers or teaching hospitals and the smaller institutions is recommended by many. Further out on the periphery of such a plan, but equally important, is the provision of diagnostic aid to doctors in areas where there is no hospital at all. Such plans promise better care for the patient and continuous education for the practitioner. Can the necessary diagnostic facilities be provided by private initiative and be accessible to all classes who need them, or should the State furnish this aid free to all physicians and their patients? Unfortunately, there is little evidence that the job can be done by voluntary effort.

In dentistry also there is the problem of providing for postgraduate education, but it is not so acute or important in this limited field. In the field of nursing, similar needs are encountered, but it is believed that in general they are being met reasonably well through the requirements, facilities, and financial assistance of the hospitals and public agencies that employ them.

The quality of care provided by hospitals has undoubtedly been improved through the efforts of nonofficial bodies such as the American Medical Association, American Hospital Association, and the American College of Surgeons. They do not touch, however, some hospitals which are most in need of improvement. To guarantee good standards in all hospitals, some element of compulsion seems necessary. Only two States have licensure laws for institutions caring for sick people and, in general, actual supervision of quality of care is lacking. The enactment of more stringent regulations and

supervision of and assistance to hospitals by governmental agencies would serve to raise standards without impairing the independence of the institutions.

Ignorance and apathy is a problem imposed more by patient than by physician. Even when medical and hospital care are easy to get, there are many who will not seek it. These include not only the bare-foot boys in the hills but also the well-heeled people of Park Avenue. The former may buy snake oil, but the latter take vitamins. Despite the striking accomplishments of public-health agencies in the prevention of disease and premature death, there remains an often discouraging degree of apathy toward acceptance of such obvious preventive measures as immunization against diphtheria or vaccination against smallpox. People are most concerned about their health when they have lost it. Fear, ignorance, and superstition still result in seriously delayed diagnosis or treatment of cancer and tuberculosis, or even in obtaining dental care. This is mentioned only to point out that the provision of personnel and facilities and the removal of economic barriers is not enough to insure a healthy citizenry. People are more sophisticated today, but there is need of large and frequent doses of public education in preventive medicine and in all matters of health.

When all other problems of medical care are disposed, there is still the problem of payment and the money barrier is probably the biggest of all. At present the provision of medical and hospital care falls into three broad patterns: (1) Private arrangements and payment of charges as incurred; (2) voluntary insurance for employed persons and, generally, their dependents, the costs being met by individual contributions, with or without employer participation; and (3) free or low-cost care for persons unable to provide it for themselves, the costs being met from general tax funds and to some extent by charitable contributions.

The first and third systems are generally recognized as being inadequate. Under the first system, the resources of the many families and individuals subject to more than the average amount of sickness are too small to pay for the costs incurred or for care needed, but not obtained. Under the third system, where care is paid for by taxes and charity, it is often limited to emergencies or obviously serious conditions. Further, many people are not inclined to accept charity or relief unless very hard pressed. Failure to seek care early may result in death or disability and involve an economic and social loss to the community. The decision to forego care from these sources may be within the province of the adult for his own need, but it is unfortunate indeed when such a decision deprives a child of the opportunity for health and fitness. In theory these two systems might, but in fact do not, make for good medical care. There is a large group between poverty and affluence who are benefited little by either of these systems.

It is the hope of many sincere persons that the second system, voluntary insurance, may fill the gap between the two other systems. Voluntary hospital insurance or Blue Cross Plans have caught the public eye. They are well promoted and most of them are well managed. With an enrollment now of about 12 percent of the population of this country they have made an enviable record in the past decade

It is difficult to predict the potential growth of these plans, however, for the barriers to growth are often outside the plans themselves. For example, recession of employment after the war may restrict them even more to the comfortable classes. The plans are sincere in an effort to provide uniform and comprehensive coverage and to cut out the common exclusions. But here and there determined and selfish opposition by middle-aged minorities of successful specialists prevents the inclusion of such recognized hospital services as X-ray and anesthesia which for many years have been part of the hospital bill in most hospitals. The success of inclusive rate systems in hospitals is proof that patients do not prefer a multitude of separate bills for hospital care. Is there any way in which the State can assist and hasten the growth of these voluntary efforts or must this bickering go on until the State takes over the job?

Medical insurance plans of the voluntary noncommercial type are now stimulated by the fear of governmental action but their record is not a good one. They protect less than 2 percent of the people of the country and that protection is mainly against the professional fees of surgery and obstetrics. Few offer service contracts comparable to those of the Blue Cross hospital plans. Most are for a cash indemnity against an unknown fee and offer little more than the protection of commercial contracts. Their development has been embroiled for a decade in details of medical ethics and attitudes and to quote one distinguished physician, "A large part of the thinking public has become convinced that the organized profession is simply fighting a rear guard action against the advance of a necessary social reform." It is apparent from public polls and from press comment that the public is impatient and this impatience is reflected in national and State legislatures. Within the past two weeks, it has been announced that Governor Warren will introduce at once legislation for a compulsory health program to protect 6,000,000 citizens of California. Again the question—can the State assist and hasten the organization and development of voluntary plans of medical insurance?

I favor the principle of private and voluntary action, but I fear that the expansion of voluntary insurance will not meet the problem from the viewpoint of the general public health and welfare. The difficulties met with are mainly these: Voluntary medical insurance is actuarially sound only when applied to employed groups; otherwise there is a distinct tendency toward short-term enrollment by individuals or families who know they need care at once. The premiums are not graded in accordance with ability to pay and there are many families whose cash income is so low that they are unable to pay the premiums of the voluntary insurance plan. There are many people who will not provide voluntarily for their own protection. It is not within the province of this paper to attempt to chart the best course through this rough sea of medical care problems. I have mentioned only some of the hazards of navigation—natural and man made. I assume there are many here today who also would like to see medical care made more available to the people who need it and who have hoped that, by voluntary effort, prepayment plans could be made to reach a decent proportion of the population. Let us look at the record. The voluntary hospital insurance plans have done a creditable job. They protect fairly well about one-eighth of the people of the United States. The same cannot

be said of the voluntary medical insurance plans. Harassed and heckled by squabbles and brawls, they have made so little progress that both labor and management have pleaded for a more realistic, business-like, and social attitude. The job will not be done by pious references to the American way of life or flaming attacks on Federal or State Governments for daring to regard health as a problem not only of private enterprise but also of public service. It would be more logical for private enterprise in this field to recognize the truth of the old maxim, "Salus populi suprema lex esto" and to propose some method by which government could participate in the promotion and financing of voluntary plans. I believe industry is willing and anxious to lend a hand to voluntary efforts but the efforts must be sincere and vigorous. Failing that, Government surely will take over the task and the only subject for discussion then will be Who killed Cock Robin?

## IX

### THE SOCIAL ASPECTS OF MEDICINE

(By Dr. E. A. Park, M.D.)

(Journal of Pediatrics, August 1945, pp. 202-205)

The physician called, when the child is born, is the pediatrician, and his problem is to keep the new baby well. And since, as the baby grows into the child, the child continues in need of guidance and protection, the pediatrician remains a practitioner of preventive medicine. The pediatricians of this country in particular owe a large debt to that really great man, Dr. L. Emmett Holt, not only for starting pediatrics as an organized department of medicine but for giving it a great shove along the road of preventive medicine, the momentum of which can still be felt. I was a pupil of Dr. Holt in 1904 and 1905 and can testify that the obligation to keep the child well was always in the forefront of his mind. This was the motive force which caused him to write his guide of questions and answers for mothers which exercised probably a greater educational influence among the laity on the upbringing of children than any other book which has ever been written. His textbook, so influential in molding the thought and attitude of physicians, differed from others in that so much of it was devoted to the ways of keeping children healthy.

But whatever the reasons, pediatricians have been among the first to be concerned with raising and maintaining the standards for the production and distribution of milk. They were the ones who established and conducted the infant welfare stations, where they acted not only as physicians but also as individual teachers to the mothers, furnishing the community with a preceptorial type of instruction regarded as so valuable in our universities. They have been the teachers of the art of feeding and raising children and have recently extended their responsibilities into the field of mental health. The pediatrician of today represents the finest type of general practitioner in that in his attitude, feelings of obligation for the general welfare of his patients, and his practice of preventive medicine he represents what the ideal family physician should be. I mention all this because I believe that the pediatricians have an advanced point of view which should enable them to face the future in a particularly liberal frame of mind, and because I think that from inheritance as well as from the requirements of their daily professional lives they are the ones who should be leaders in the social reorganization of medicine which is bound to come.

All thoughtful people are conscious that great changes in the organization of society the world over are in progress. These had been developing obviously enough prior to the outbreak of this present war, but the war, with its loosening and stirring-up processes, has



undoubtedly intensified their progress. We are in the beginning of a great social upheaval. No one can foresee just what changes will result, but it is possible to speak in generalities. A movement throughout the world toward the left, which has as its ostensible object the improvement in the conditions of the average man and his family, is in process. More consideration is going to be given and better provision made for economic welfare, housing, comfort, recreation, and, in particular, for the maintenance of health and for safeguard against helplessness during periods of joblessness, illness, and old age. The power of the individual to acquire great wealth is going to be diminished, and institutions such as our private hospitals, endowed medical schools, and universities on private philanthropy will have to look for support to other sources, very probably to the state. There is undoubtedly going to be increased power vested in the state; in other words, in spite of every desire to maintain individualism and power of initiative, more centralized control is going to be forced upon us, for the reason that such is the simple, direct way for the people to get these things which they so fervently desire. Medical care is so insinuated into the structure of society that inevitably it will be caught in the general upheaval and will share in the changes in general. No one can foresee just what the changes in medical care will be, but it is safe to say that, whether we like it or not, they will be considerable, that they will be initiated and dictated largely by the lay public, that the preventive aspects of medicine will have a much more important place than at the present time, and that medical care will be extensively reorganized and increasingly regulated and controlled by centralized authority.

All that we have to do in order to appreciate the truth of what has just been said is to look at the world around us. Take England, for example. In England the National Health Insurance Act, carrying with it the so-called panel system of medical care, was forced through Parliament in 1911 by the Lloyd George government against the most determined opposition of the British Medical Association. Looking back at what happened, one can see that the legislation was a revolt of the public from the leadership of the medical profession. The panel system was full of defects which were subsequently partially rectified through the aid of a committee of physicians appointed by the Ministry of Health. It is generally conceded that had the physicians of England tried to guide instead of uncompromisingly oppose, they could have made the panel system much better for the public and for themselves from the outset. In 1943 the Beveridge plan, which contains an elaborate system for health insurance and medical care with the creation of a system of fully equipped and staffed hospitals and health centers under state control, was made public and created enormous interest among the lay public. Indeed, the plan seemed so popular that its provisions were embodied by the Churchill government with relatively small change in the British white paper.

In Scandinavia an elaborate system of state medicine has been in operation for years, and more recently one has been introduced and put to test in New Zealand.

In this country we have witnessed the development of the Wagner-Murray-Dingell bill, and this bill in revised form is now before a committee of Congress. The Wagner-Murray-Dingell bill contains

ideas and provisions similar in many respects to those in the British white paper, including health insurance, preventive medical care, improvements in the facilities for the kind of medical care rendered, and a distribution of physicians, hospitals, and medical centers determined by community requirements instead of the location of money. Other indications of the trend in medical care in this country are to be found in the special system for medical care as set up by the Group Health Association for Federal civilian employees in Washington, D. C., over which the American Medical Association fought and sustained so conspicuous a legal defeat, and also in the organization of medical care at the Kaiser shipbuilding plant. Many other examples in which large groups of lay people have organized their own systems could be cited. The truth is that scientific advances in medicine have far outstripped their social applications. People are beginning to realize that there exists a better kind of medicine than is generally available. In particular among the great labor groups, one sees this awareness and the full intention of obtaining these advantages.

In summary, several facts stand out clearly. A movement in the field of medical care has begun, and it is plainly toward state medicine. Moreover, on every side it is coming from the people themselves. It is just a part of a much greater movement, also emanating from the people and actuated by the vision of more security and comfort and better protection from disease and its economic consequences. It is world-wide in its dimensions and has the uncontrollable force of all world movements.

We physicians have power to guide the forces of change; it is the personal opinion of the writer that we have very little power to stop them. Therefore, at this critical time, the social questions pertaining to medicine are every bit as important, if they are not more important, than the scientific ones. Yet no medical journal has thrown open its columns with the invitation to a free discussion of them. For the more radically minded, it has been necessary to go to the socioeconomic group of journals or to those devoted to public health, but these are publications which fail to reach the medical profession generally. Accordingly, at the last meeting of the Academy of Pediatrics, the suggestion was made that the Journal of Pediatrics establish a column which would have as its object the free discussion of the social aspects of medicine, one which would serve both as a clearinghouse for ideas and a source of factual information. The editors of the Journal have now embarked on this policy and have made the writer responsible for the conduct of the column.

We now come to the important question: What will be the policy of the editor of the column? In brief, it will be to present information in regard to developments of a social nature in medicine with particular stress on pediatrics and to promote expressions of ideas and discussions which will result in constructive thoughts and the development of the best policies. If any of us wished to build a hospital, one of the first things we would do would be to visit other hospitals in order to learn their good points and defects.

In making up our minds in regard to the best program for medical care in the future, a helpful step would be to learn the plans and experiences of other people. Accordingly, the editor will try to secure expositions of the systems of medical care which have been in opera-

tion for some time in Scandinavia and in New Zealand, a summary of the proposals for medical care in the British white paper, and also a critical exposition of the revised Wagner-Murray-Dingell bill, which is very difficult for the nonlegal mind to understand on account of its phraseology and intricacy. When possible, pediatricians will be secured as authors. The editor will also invite communications from pediatricians and will not exclude those of others, some of whom may not even be physicians, provided they furnish interesting and helpful ideas or information. The editor will not be disappointed if the column at times becomes decidedly "hot." Of course, it will be impossible to publish all communications which may be sent to the Journal. This does not mean that the editor will exclude matter because it differs from opinions which he may hold or develop as he goes along but rather that he will use his best judgment in selecting contributions that present different points of view. He will welcome extremes because there is nothing which brings out vigorous reactions as they do. No unsigned contribution will be accepted. It is expected that the column will have a certain amount of autonomy which will follow from the fact, understood by everyone at the outset, that the views expressed by contributors will not be taken as expressing the opinions of the editorial board or the beliefs or policies of the academy. Through all this the editor will attempt to remain as impartial and fair-minded as he is capable of being.

Before concluding, a word of caution is in order. When Galileo declared the earth round, the Catholic Church, in the person of the Pope, silenced and punished him. When Darwin brought forward the theory of evolution, obstinate opposition arose not only from the laity but also from scientists. The ideas were too big and different to be swallowed and digested immediately. The human mind instinctively dislikes change because it fears change, particularly when the change involves the unknown, leaving security for doubt. Yet all of us know in the depths of our minds that progress means change and that change in the right direction is the only way in which progress can be attained. We must all of us, therefore, in this critical time, take precautions against being prejudiced against ideas just because they are new and strange. We must attempt to obtain a detached point of view; and if new ideas seem on adequate study good, we must not be afraid to try them.

## X

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### MUST WE BE COMBATIVE?

Pick up any medical journal and one usually finds some such phrase as "we must combat." It is the war cry of most medical editors urging their readers to oppose socialized medicine, radical changes in medical practice, and further expansion in the field of medicine by the Government.

In the opinion of your observer, the reaction to this belligerent attitude is, to put it mildly, regrettable. Of course, we must defend the things for which we stand; and, if necessary, we must be willing to fight for them. But persistent combativeness becomes a little tiresome. It is, therefore, not surprising that people ask: If the medical profession is so opposed to what the Government or some agency is trying to do to improve the health of the people, what are they prepared to do themselves?

The truth of the matter is that our combativeness, even if successful, will not settle matters indefinitely so far as medical care is concerned. There are inadequacies which must be met. Physicians know this to be a fact, many lay leaders know it, and so do an increasing number of ordinary people.

Neither the laity nor the medical profession like some of the proposals which have been made. Certainly, medical service would deteriorate under some of the systems proposed and would not be acceptable to recipients or physicians. But this does not alter the fact that changes are in the making. Along with their combativeness, physicians must be willing to join with the Government and serious-minded people in seeking a healthier America.

The day when physicians considered themselves set apart from those engaged in other pursuits is gone with other types of isolationism. They might as well face the fact that medical care is now the concern of everyone. Some of our medical leaders do not act as though they believed that. They are disdainful of "lay interference," although people of undoubted intelligence and understanding have concerned themselves with health matters. Such an attitude can only be deplored. If the medical profession acts wisely, it will look at the health picture objectively, discuss the controversial issues dispassionately, and seek the cooperation of interested laymen. Only by this means will a common ground be found.

Mention should be made of the importance of the medical profession's relationship to the Government. This must somehow be improved. At present medical organizations are more frequently than not ignored. Very seldom is their advice sought. Here is something which should be remedied without delay.

Your observer believes that the combativeness of medical men who are disinclined to discuss anything pertaining to medicine with "outsiders" has contributed largely to this state of affairs. They should be warned that they are playing a dangerous game, one which may lead to disaster. "Pride goeth before destruction and a haughty spirit before a fall."

