10¢

DOCTORS, DOLLARS *and* DISEASE

Public health

Can we afford health?

How can we maintain good medical care?

How deal with patients' ills and doctors' bills?

How far shall we use insurance?

How far shall we use taxation?

Public Affairs Pamphlets
No. 10 1937

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Doctors, Dollars and Disease*

ONLY THE RICH and the poor, it is often said, get the best of medical care; the rich because they have money, the poor because they have charity. So, if you are rich or poor, you may not be interested in this discussion of new efforts to provide good medical care for everybody.

Possibly, however, you are one of the many millions in the United States who are neither rich enough in cash to be able, in an emergency, to pay a bill of $300 for medical and hospital care, nor poor enough in spirit willingly to accept charity.

If you are rich, we said, this may not interest you. But we take that back; for, whether you know it or not, you now pay some of the doctors' losses on patients who do not pay their bills. Over 40 per cent of doctors' bills are six months overdue. Most of these bills will never be paid in full. Certainly you are interested in plans which may enable some of these millions of patients to meet their own bills.

If you are poor, we said, this may not interest you. We take that back, too. The mere repetition of the statement that the poor get the best of medical care may leave you unconvinced. Even if such care were available, you might resent being a charity patient.

You always expected to carry your own weight; but

* This pamphlet, prepared by William Trufant Foster, is based on the 28 volumes issued by the Committee on the Costs of Medical Care, studies by the Twentieth Century Fund and the Julius Rosenwald Fund, reports of the American Hospital Association, the American College of Surgeons, the American Medical Association, and the United States Public Health Service, and reports of many new agencies which are providing medical and hospital care, one or both, on a group payment or annual fee basis.

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then came paralysis or a crashing of automobiles. Suddenly you found yourself overwhelmed with doctors' bills, nurses' bills, and hospital bills. For the first time, you belonged to the 10 per cent who, in any one year, bear 41 per cent of the

SICKNESS COSTS FALL UNEVENLY

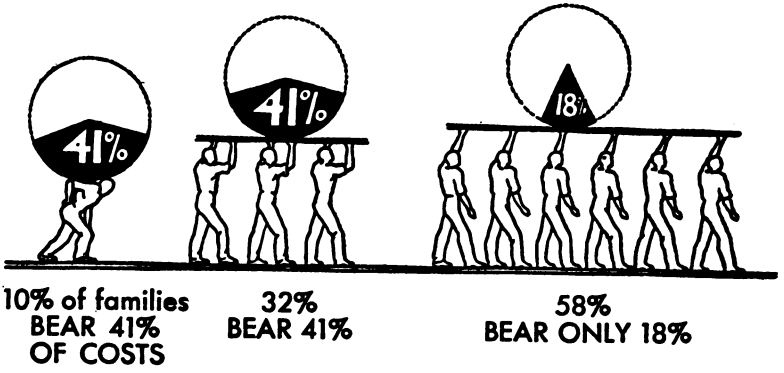


Chart No. 1

nation's bills for sickness. (See Chart 1.) To make matters worse, your wages stopped precisely when your expenses increased. Certainly you would like to know whether it is possible, by paying moderate fees in advance, to insure against such crushing, unpredictable costs.

What Happened to Henry Brown?

You know what happened to your neighbor, Henry Brown. You know his family tradition of self-reliance; how in spite of low wages he always prided himself on paying his bills promptly. Then came that baffling illness. He postponed seeking aid, fearing large bills. Then he went from one specialist to another, blindly seeking aid. He became weaker and weaker. Now, his savings gone, his job gone, and his wife broken down under the strain, he is mentally losing his grip.

Suppose that Henry Brown, by paying a monthly fee within his means, say two or three dollars, had been entitled

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to diagnosis by a fully-equipped group clinic and free hospitalization. Could this family tragedy have been prevented? Perhaps not, but the question is worth discussing. Would his peace of mind concerning expenses have aided his recovery? Very likely.

Suppose, further, that the group clinic had induced Henry to have a thorough health examination every year. Might his illness have been prevented? Again, perhaps not. Every doctor knows, however, that many illnesses *are* preventable if treatment is given in time, and that as means of prevention thorough periodic examinations are essential. Yet, how many Henry Browns in your community have had such an examination this year? Not one in ten, if your community is typical.

And how many have had the needed dental care? Perhaps one in four.

Henry Brown's community is typical of many large centers in another respect. There was a fully-equipped private hospital not far from Henry's home, with many beds unoccupied. Henry needed the hospital; the hospital needed patients.

Can we not find a way to use our hospitals even in "hard times"? And our doctors, dentists, nurses and technicians? Many of them, especially when payrolls fall off, spend much of their time waiting for patients who do not come.

Should not all the Henry Browns, collectively, pay doctors and dentists to keep them well, instead of waiting until they have tuberculosis or a toothache? And would not doctors gladly try to keep them well, if collectively they paid them flat salaries to do precisely that? The answer is that we don't know and won't unless we are willing to try at least a few experiments with new ways of paying doctors' bills.

Is Henry Brown's Community Really Typical?

A survey of 9,000 families living in 130 communities in 18 states and representing various economic levels shows that

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Henry Brown's case is not unique. Each family was observed for one year through repeated visits made by a public health nurse. Full records were obtained. They showed that the

9 OUT OF 10 SCHOOL CHILDREN HAVE DECAYED TEETH OR OTHER DISEASES *of the* MOUTH



1 OUT 5 APPLICANTS FOR THE U.S. NAVY *in* 1933-1934 WERE REJECTED BECAUSE OF BAD TEETH *or* OTHER DISEASES OF THE MOUTH



SOURCES { The OFFICIAL REPORT OF THE BUREAU of MEDICINE and SURGERY of the U.S NAVY. ESTIMATE FOR SCHOOLS BASED ON PUBLIC HEALTH BULLETIN #226 "DENTAL SURVEY of SCHOOL CHILDREN" U.S. PUBLIC HEALTH SERVICE, WASHINGTON, D.C.
Arranged by THE NATIONAL FORUM.

Chart No. 2

medical care received by this representative group of American citizens fell far short of reasonable standards. The service from physicians was only 43 per cent of that considered

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essential for adequate care; the hospital care was only 25 per cent of the standard, and the dental care only 24 per cent. At least one visit to a dentist each year for every person over three years of age is essential; yet these 9000 families enjoyed less than one-quarter of this essential service. (See Chart 2.)

Despite the large volume of free work done by hospitals, health departments, and individual practitioners, and despite the sliding scale of charges, it appears that more than half the avoidable deaths of mothers at childbirth are caused by deficiencies of medical care. So says the New York Academy of Medicine. More than half the sick in certain crowded centers receive no medical care whatever. So says the United States Public Health Service. Only three decaying teeth out of ten now receive dental care: the rest just keep on decaying. So says the Committee on the Costs of Medical Care.[1]

The Committee concludes, after five years of research, and the expenditure of seven hundred thousand dollars, that our failure to make full use of our hospitals, nurses, doctors, and dentists causes a vast amount of preventable economic waste, physical pain and mental anguish, as well as many needless deaths. Indeed, under the prevailing form of medical practice—individual services for individual fees—a large proportion of the population, in any one year, either do not receive the care they need or are hopelessly burdened by the costs.

The recent progress of the science of medicine has been little short of miraculous. Physicians and other men of science have shown almost unparalleled professional spirit in making available the results of their research. Innumerable physicians,

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[1] The Committee had 48 members, of which 27 were doctors of medicine. Of the doctors of medicine, 17 were engaged in private practice. The Chairman of the Committee was Ray Lyman Wilbur, President of Stanford University, former Secretary of the Interior, and former President of the American Medical Association. Seventeen doctors of medicine and 18 other members signed the majority report.

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especially family doctors, have risked their lives in serving mankind without regard to money reward. Great gains have been made, mainly on the initiative of the medical profession, in standards of education and of practice; and in many branches of medical and dental science the United States leads the world. Moreover, the American Medical Association, by persistent exposure of fake medicines, has protected the public from many frauds; and recently there have been effective extensions, notably with respect to syphilis, in our public health service.

Yet here, roughly, is the net result: our present facilities, if fully used, would provide nine-tenths the medical care and one-half the dental care which satisfactory standards require, whereas actually we now have only about half the required medical care and only about a quarter the required dental care.

Why So Much Concern About the Costs?

"Why so much concern about the *costs* of medical care?" writes a critic. "Who wants to visit a dentist, anyway? If Henry Brown had had more money, would he have bought more dental services for his family or more candy, cosmetics, and chewing gum? The main reason why people neglect their teeth is not lack of money."

There is much point to this comment. Many families of moderate means now waste enough money to provide good dental care. Nevertheless, in the course of a year, 90 per cent of the members of families which have incomes of less than $1,200 receive no dental care whatever, whereas the figure is only 40 per cent among families with incomes over $10,000. (See Chart 2.) Even in prosperous times, 61 per cent of the families of wage-earners in Boston, New York, and Philadelphia spend nothing for dental care. Apparently, any plan

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which overcame the economic causes of this neglect would more than double the number of persons who receive adequate dental care, no matter what might happen meanwhile to the consumption of candy, cosmetics, and chewing gum.

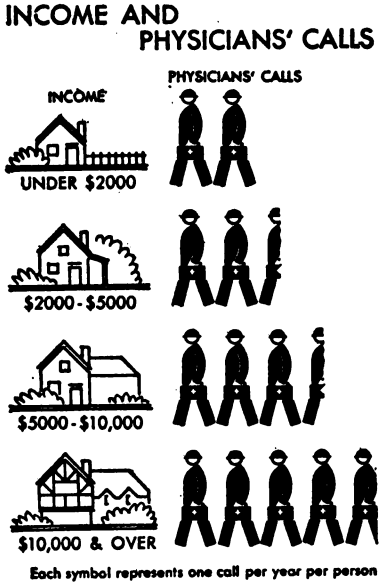


Chart No. 3

Moreover, need for care is far greater in the lower-income groups. A study of 15,000 families in ten cities shows that the poorer the families, the higher is the rate of disabling illness among them.

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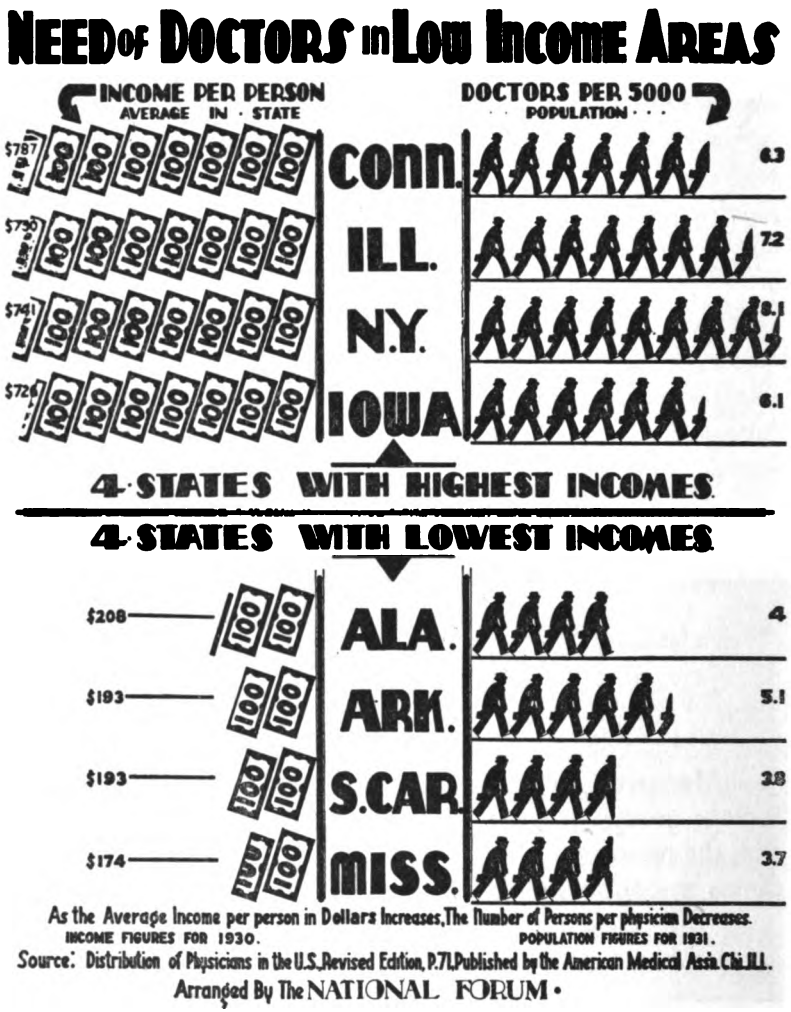


Chart No. 4

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WHY DON'T WE ALL RECEIVE GOOD CARE?

MEETING the costs of good care is not the only problem. Another is that often the patient, as in Henry Brown's case, does not know what kind of medical aid he needs. How *can* he know, unless he is so fortunate as to have the aid of a family physician of the finest type, of which there are many, but not enough? Even when he *does* know what he needs, he may not know where to find it. He may drift around or be sent around for weeks, from one specialist to another, or to quacks and cultists, all the while with decreasing funds and increasing pain.

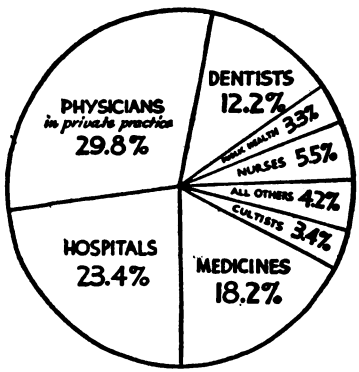
Still another problem is that our extensive medical facilities are not distributed according to need. About 1,000,000 persons in this country provide medical care and depend upon it for their livelihood. There are nearly 7,000 hospitals, with about 1,000,000 beds; 8,000 clinics and out-patient departments of hospitals; 57,000 drug stores; and many state, county, and municipal health departments. Yet, in relation to the number of persons to be served, there are only one-third as many physicians in South Carolina as there are in California; and more than a thousand counties in the United States have no hospitals for general community use. An abundance of facilities in one community does not help those without facilities in another community. (See Chart 4.)

Worse still, millions of men and women believe in incantations as a cure for smallpox or in other remedies of the same fascinating nature. For this reason much of the money that is now spent for medical care is spent to poor purpose. Each year, at least $125,000,000 are spent for the services of naturopaths, faith healers, and similar groups, and $360,000,000 for patent medicines. Much of this is wasted—or worse!

Finally, among the main reasons why we do not all

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receive good medical care, is the fact that we spend too little on *prevention* of disease. We now spend every year for medical care over three billion dollars, yet only one dollar out of every thirty goes to public health services for the *prevention* of disease. The other twenty-nine dollars are spent in treating disease. (See Charts 5 and 11.) Does not every collection of statistics of this sort reveal our collective stupidity?



HOW WE SPEND
3½ BILLION DOLLARS
EACH YEAR

Chart No. 5

These, then, are some of the conditions which must be taken into account in formulating a plan or plans for the care of all the people and payment for all the services. These conditions are the outcome of social evolution; they are not the fault of the medical profession or of any other group. They must, nevertheless, be faced.

Another problem is that medical costs which are too high for many families to pay do not necessarily guarantee high incomes to most of the practitioners. For every physician who, in the "boom" year of 1929, received a professional net income above $10,000, there were two who received less than $2,500. The contrast is especially great between the incomes

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of general practitioners and the incomes of specialists. Evidently, no solution to the problem of medical costs can be reached through a reduction in the average professional income.

The solution of the problems, evidently, is to bring Doctors, Dollars, and Diseases into such helpful and continuous contact with each other that the practice of medicine can keep pace with the science of medicine.

CAN WE AFFORD GOOD MEDICAL CARE?

But can we muster enough dollars for the purpose? Medical care now costs us about three and a half billion dollars a year—almost as much as we spend to ride around in motor cars. (See Chart 6.) *Adequate* medical care for all

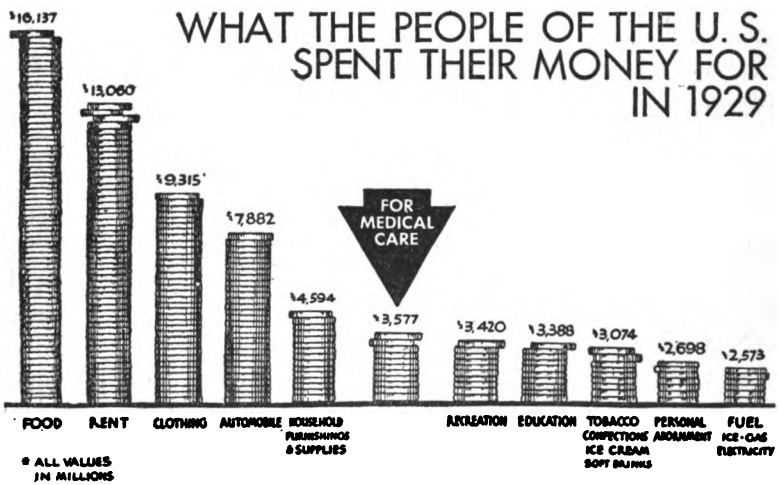


Chart No. 6

the people, even after all possible reduction of wastes, would cost more. Can we afford it?

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Clearly we can, even with the present national income. To be sure, once we contrive to distribute consumer commodities and services as rapidly as we can readily produce them, we shall greatly increase the national income. But the present income is enough. If we abolished the reducible wastes of our unbusiness-like methods in the field of medical economics, $36 a year per person would suffice, and already we are spending about $30. An increase of $6 would meet all needs. This means that we could give 126 million people the benefits of the astounding advances which have been made during the past generation in medical science, if we spent—and spent efficiently, merely as much money for medical care, as we spent in the darkest days of the depression for candy, cosmetics, chewing gum, and cigarettes.

New inventions, new discoveries, new reductions of waste, and large-scale production are constantly increasing output per man-hour. The United States will continue to have a productive capacity far in excess of any which it has yet used. This probably will make possible, within three decades, a standard of living at least 30 per cent above the present level.

What use of our increased income will yield the largest possible satisfactions? Should we plan to increase expenditures for food, clothing, amusements, automobiles, cigarettes, cosmetics, medical care, and so on, each in proportion to present expenditures? Clearly not. The greatest satisfactions will come if a comparatively large part of the increased income is used for the preservation of health.

In other words, we should use more of the gain for services than for commodities, and high among these services should be medical care, particularly preventive care. Nothing we are likely to buy with an additional billion dollars will mean so much to us as health, especially—we repeat—if the money is spent efficiently. What can we do about that?

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WHAT CAN WE DO ABOUT THAT?

First of all, the medical profession might insist on doing nothing more than we have done in the past. But in that case, something more *would* be done. It would be done, unfortunately, without the leadership of the medical profession. For example, we might attempt to solve the whole problem quickly by a single, sweeping program, administered by the Federal Government. We might take over bodily one of the European systems of health insurance, ignoring differences in conditions which might make the program a success in one country and a failure in another. Or, in attempting to take care of everybody by means of taxation, we might leave politicians free to do their worst. Thus we might get more medical dollars, more medical services, and less medical care. Or we might get equally bad results by having medical services controlled by business men who thought that patients could be treated by mass production methods, like automobiles in an assembly line. In short, by suddenly forcing upon the entire country new methods of providing medical care and paying the bills, we might make mistakes which, if they must be made at all, could be made more prudently on a small scale.

Shall We Try Voluntary Insurance, Compulsory Insurance, Public Medicine, or All Three?

There are three ways and only three of solving the problem: voluntary insurance, compulsory insurance, and public medicine. In order to extend the use of any one method, we do not have to renounce the others. We can have all three, and at the same time maintain the private practice of medicine on the individual fee-for-service basis, for those who want and are able to pay for such service. Indeed, unless we provide free care for everybody who wants free care, and

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pay the bills out of increased taxes, we *must* have some form of health insurance.

Why Do We Need Health Insurance?

Most of us, perhaps 80 per cent or more, could plan in advance to pay our own bills if we were "average" individuals. (See Chart 7.) But in any one year the costs of illness fall so heavily on a few of us, and are so far from predictable, that budgeting the bills is impossible. In any one year the

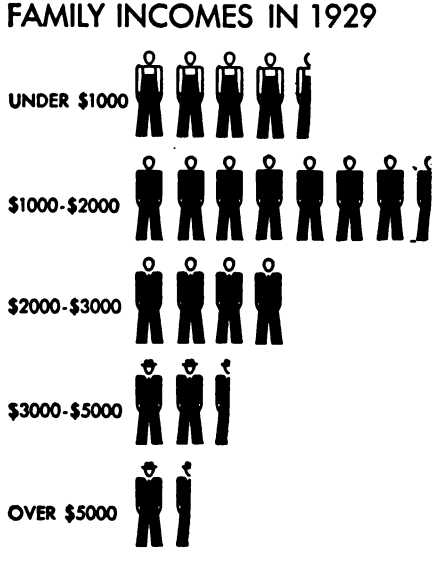


Chart No. 7

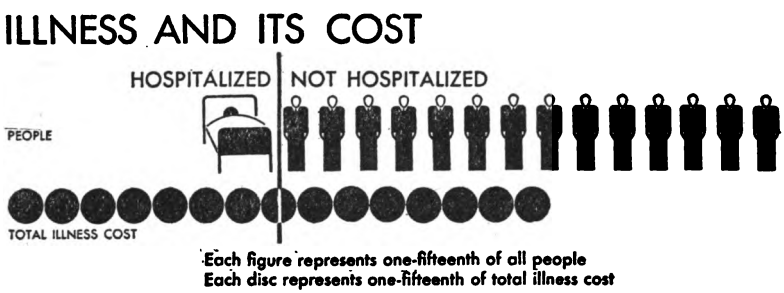
most unfortunate 5 per cent of the families pay *nineteen times* as much per family as the most fortunate 70 per cent; and in any one year, only one person out of fifteen needs hospital care. (See Charts 1 and 8.)

Under such conditions, the "average" cost per family is a useless abstraction. The high-expense, low-income families cannot pay their bills, merely because the *average* costs of

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medical care are not excessive for families with *average* incomes.

It is impossible for a large majority of families to set aside any reasonable sum of money, with positive assurance that no more will be needed for medical care. Such risks, like fire



(Half the family bills for illness goes for hospital care— but in any one year only one person in fifteen *has* hospital care)

Chart No. 8

risks, call clearly for group prepayment of costs on an insurance basis, or for some other form of collective financing of medical and hospital bills. Patients, as individuals, cannot solve this problem. Neither can doctors, as individuals.

HOW CAN GROUPS VOLUNTARILY BUDGET THEIR HOSPITAL BILLS?

THE American College of Surgeons holds that the voluntary, periodic, pre-payment plan—group insurance—for families of moderate means offers a reasonable expectation of more effective methods of securing medical service. The College believes that plans for the payment of hospitalization alone, without provision for payment for medical service, may well be the first project to be undertaken in the average community. The American Hospital Association, through its Committee on Hospital Service, (C. Rufus Rorem,

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Director, 18 East Division Street, Chicago) is assisting communities throughout the country in getting group hospitalization projects under way on a sound basis.

Already these projects, based on the principle of insurance, are accomplished facts in more than 60 cities.[1] On February 1, 1937, more than 750,000 subscribers and their dependents were placing hospital care in the family budget by paying subscriptions of 50¢ to 85¢ per month per person. In New York City alone, the "three cents a day" plan enrolled more than 225,000 employed subscribers and dependents and more than 200 participating hospitals. Three weeks' hospitalization is guaranteed upon payment of $10 per year by an employed person. For an additional $8 the subscriber's spouse may be enrolled, and for $6 more ($24 in all) a subscriber may enroll himself and his entire family for complete hospital care in a semi-private room, including all special services such as laboratory, operating room, and x-ray service.

An Example of Group Hospitalization

The plan in use in Rochester, New York, is typical. In 1934, a group of hospital executives in Rochester advocated removing hospital care from the class of economic hazards and making it a purchasable service. The six hospitals agreed to participate and a corporation was formed, under a law by which the State Department of Insurance supervises and regulates non-profit hospital service associations. The trustees include hospital administrators, practicing physicians, industrialists, subscribers and the general public.

Any employed person, upon payment of 65¢ per month,

[1] Including Washington, Wilmington, New York, Albany, Utica, Syracuse, Rochester, Buffalo, New Haven, Cleveland, Chicago, Minneapolis, St. Paul, St. Louis, New Orleans, Sacramento, Oakland, Norfolk, Richmond (Virginia), Dallas, Houston, San Antonio, Durham, Birmingham, Kingsport (Tennessee), Brattleboro (Vermont), Peoria (Illinois), Geneva, Jamestown (New York), Chapel Hill (North Carolina), Bluefield, Charleston (West Virginia).

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becomes entitled to three weeks of hospital service without charge in semi-private accommodations. The patient may select any hospital in which his attending physician enjoys staff privileges. The benefits do not include payments to the attending physician or surgeon, or in any way interfere with the subscriber's relationship to his physician or the physician's relationship to the hospital. Patients may receive benefits only upon recommendation of, and while attended by, a private physician or surgeon.

Hospital service includes board and room, floor nursing, operating room, anaesthesia, drugs, dressings, laboratory, metabolism tests, insulin, oxygen, physical therapy, ambulance, and all routine services. The illnesses covered include all accidents and injuries admissible to a general hospital, except workmen's compensation cases, venereal diseases, tuberculosis and mental cases. All services for maternity cases, including use of the delivery room, are provided at half price after a period of ten months. For these services the participating hospitals are remunerated from the group fund at a flat rate per hospital day which covers the full costs.

The plan was introduced in Rochester in June, 1935. Eighteen months later there were 30,485 employed subscribers and 24,826 dependents eligible to benefits. During this time 2,983 subscribers and dependents were hospitalized, for whom the Association paid the hospitals $120,000. Subscribers are eligible to benefits anywhere in the United States and Canada. The "overhead" costs of administration have been 12½ per cent of the total subscriptions, and a "reserve" of more than $75,000 has been accumulated for use in case of epidemics or catastrophes. The dependent coverage has since been increased to approximately two-thirds of the hospital bill. Meanwhile the initial working capital, which was advanced by the six hospitals, has been repaid in full.

Group hospitalization is not a panacea for the economic difficulties arising from sickness, but it has definite advantages.

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In the first place, many persons with limited means are admitted as paying patients, who otherwise would go into free wards; for many persons are able to budget a dollar per month while employed who would be unable to pay from $50 to $100 for hospital care during a period of sickness. In the second place, physicians find it possible to hospitalize cases requiring such treatment, where they otherwise would hesitate to incur such costs or to request charity. Moreover, freedom from worry over hospital costs aids recovery; and some patients who might have spent all their available funds for hospital care are now able to pay their doctors.

Group hospitalization does not help the indigent or the unemployed: the principle of budgeting assumes the existence of an income from which to budget. For other persons, however, group budgeting does remove one economic hazard, without interfering with their choice of physician or hospital.

CAN WE EXTEND VOLUNTARY GROUP PAYMENT PLANS TO COVER DOCTORS' BILLS?

THE principle of insurance, now generally approved and widely used in group pre-payment of hospital bills, can be applied to group pre-payment of doctors' bills, on either a voluntary or a compulsory basis. A majority of the Committee on the Costs of Medical Care recommend voluntary group payment of doctors' bills, in any community which feels disposed to try such an experiment.

In California, the state medical society not only endorsed this principle, but proposed a plan whereby the county medical societies might offer medical care in return for a stated annual payment. In Tacoma, Portland, Oregon, and in some smaller places, the county medical societies have organized

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"service bureaus" which are furnishing services to substantial numbers under annual payment agreements. Each subscriber pays so much per year, and his doctors' and hospital bills are paid for him, whether he has much or little sickness. In Seattle, the King County Medical Service Bureau offers the services of more than three hundred doctors to groups of employed persons.

Voluntary Health Insurance and Group Practice Through Consumer Cooperatives

Under the guidance of the Bureau of Cooperative Medicine of the Cooperative League of the United States, voluntary health associations are being organized in which groups of physicians, each practising his specialty, furnish the needed medical services, and members pay for these services on a periodic fee basis. Since these associations govern themselves on a democratic basis, there is no "third party" between the doctor and the patient. The cooperatives come to the medical profession seeking the medical service. There is no solicitation by the doctors. The members voluntarily budget their entire medical costs and it is said that, because of group practice and resultant economy of time, the medical men who serve the cooperatives are enabled to do better work.

An Example of Voluntary Health Insurance and Group Practice Combined

The Ross-Loos Medical Group of Los Angeles, California, combines group practice with voluntary health insurance. This group is operated by a staff of approximately forty full-time physicians. The medical services include house calls, diagnosis, medical treatment, surgical treatment of all kinds, eye tests and hospitalization. Members receive all services and supplies free, except eye glasses and certain types of expensive

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medicines. The costs of the services are $2 per employed person per month.

Dependents of members may receive all professional services, but are required to pay for hospitalization and for certain supplies or apparatus. During the year 1934, the average extra charges for home calls, hospitalization, medicines, etc., were 68¢ per family per month, making a total cost of $2.68 for complete medical, surgical, and hospital care, not including dental service. Recently there were approximately 20,000 employed subscribers representing more than sixty different groups, constituting with their families over 60,000 persons.

Each group of employed persons has a contract with the Ross-Loos Medical Group. The Group is organized as a partnership under the laws of California. Financial and professional arrangements between the clinics and the groups of subscribers are negotiated by health committees in each group. All complaints and adjustments must be made through these health committees. No employed solicitors are engaged to sell contracts.

Other Voluntary Health Insurance Plans Now in Use

Many other plans now in use enable the beneficiaries to purchase medical care voluntarily by means of periodic payments. These plans include the Benefit Association, Brattleboro, Vermont; Student Health Service, University of Michigan; Community Service, Roanoke Rapids, North Carolina; Fulton County Medical Relief, Atlanta, Georgia; Trinity Hospital, Little Rock, Arkansas; Stanocola Employees Association, Baton Rouge, Louisiana; and Farmers' Union Cooperative Hospital Association, Elk City, Oklahoma. All these and other examples of organized local plans for providing or paying for medical services in the United States are described in "New Plans of Medical Service," a pamphlet published by the Julius Rosenwald Fund, Chicago.

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COMPULSORY HEALTH INSURANCE

COMPULSORY health insurance, rather than voluntary, is the basis of the plan before the Canadian Medical Association, as well as plans offered by lay groups in this country, including the American Association for Social Security, the technical staff of the Milbank Memorial Fund, and some members of the Committee on the Costs of Medical Care. The proponents of compulsory health insurance point to experience abroad and under our own workmen's compensation measures as proof of the greater economy and effectiveness of a compulsory system.

One health insurance program is outlined in the model bill of the American Association for Social Security which has been presented in a number of states as well as in Congress. Under this bill all manual workers and all persons earning less than $60 a week contribute to a system which provides medical as well as cash benefits. The medical benefits commence immediately upon entrance into the system, extend to the family of the insured, and continue for an unlimited period. They include regular medical care as well as indispensable surgical, hospital and dental services. The cash benefits for the insured are around 50 per cent of wages, with additional allowances for dependents. These are granted after a waiting period of 26 weeks. The method of remuneration of doctors is left to the medical profession in each locality and free choice of doctors guaranteed. The right to cash benefits is decided by full-time public officials rather than by doctors. The costs, paid by the government, the employer and the employee, are higher for workers who earn large salaries and lower for others.

The British Health Insurance System

The British compulsory health insurance system has from its beginning in 1911 included in its medical benefits only the

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services of a general practitioner. It does not include the services of specialists or hospital care. Cash benefits are provided for a specified period during sickness. All persons employed at manual labor and all other employed persons with annual incomes of less than $1,250 are required to insure. These employees pay approximately 40 per cent of the total cost, the employer paying about the same amount, and the state the remaining fifth. Over 18 million persons are thus insured under the law and about 16,000 physicians have elected to serve.

The following resolution was passed by the British Medical Association almost without dissent: "The measure of success which has attended the experiment of providing medical benefit under the National Health Insurance Acts system has been sufficient to justify the profession in uniting to secure the continuance and improvement of an insurance system." It is ten years since that resolution was passed. Since then further resolutions have been adopted pressing for an extension of the system.

A Royal Commission in National Health Insurance lists these gains: "(a) large numbers, indeed whole classes, of persons are now receiving a real medical attention which they formerly did not receive at all; (b) the number of practitioners in proportion to the population in densely populated areas has increased; (c) the amount and character of the medical attention given is immensely superior to that formerly given in the great majority of clubs; (d) illness is now coming under skilled observation and treatment at an earlier stage than was formerly the case; (e) the work of practitioners has been given a bias towards prevention that was formerly not so marked; (f) clinical records are being provided which may be made of great service in relation to public health and medical research; (g) co-operation among practitioners is being encouraged to an increasing degree; (h) there is now a more marked recognition than formerly of the collective

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responsibility of the profession to the community in respect of all health matters." These are described by the Commission as "immense gains."

To quote Sir Henry Brackenbury, M.D., a member of the Royal College of Surgeons of England and Chairman of the Council of the British Medical Association:

"The results to the medical profession itself have also been, in general, advantageous. The system has, in almost all areas and in the case of a large proportion of individual practitioners, increased the feeling that we are colleagues rather than rivals, and has brought about a more conscious relationship between family practice and various aspects of public health service. These are considerable gains. Financially, too, the effects have been beneficial. The aggregate income of members of the profession practicing under the scheme has been largely augmented. There are probably thousands of general medical practitioners today who, without the insurance scheme, would not have been able to earn by the exercise of their profession a sufficient income on which to live. . . . In addition, a large number of physicians find it a relief and comfort that they can now give full attention to many of their poorer patients without the thought that those patients will be afterwards distressed by the presentation of a bill. There is no evidence that the general quality of professional work has in any way deteriorated."

The question remains, however, whether compulsory health insurance would be equally successful under the different conditions which prevail in the United States. In any event, the question may well be raised whether the most prudent course is not to try a few programs in a few states and let all the states profit by these experiments. If compulsory health insurance is as poorly suited to the needs of this country as some persons believe it to be, presumably the best way to settle the question is by trying a few small-scale experiments.

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HOW FAR SHALL WE EXTEND PUBLIC SERVICES?

We now have public medical and health services in various customary and accepted forms, paid for out of receipts from taxation. More than 1,700 government hospitals afford nearly all the care of mentally-ill patients, much of the care of sufferers from tuberculosis, and an increasing amount of the care of sufferers from some other diseases. (See Chart 9.) We have health departments which are con-

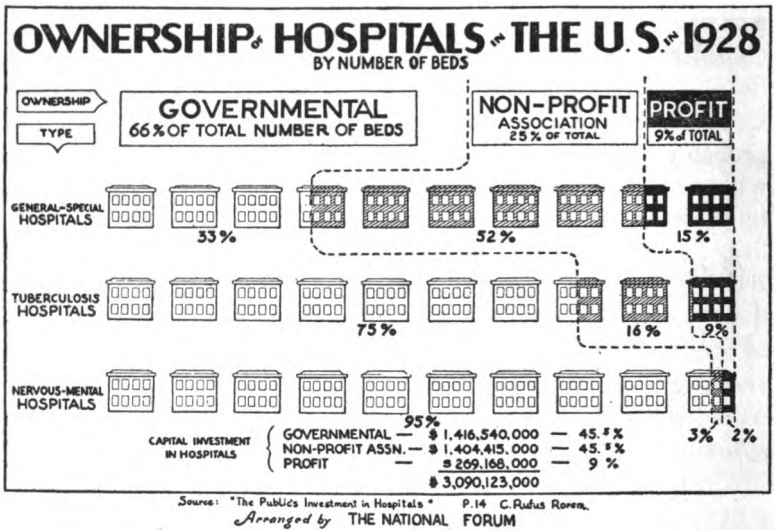


Chart No. 9

cerned with control of milk and water supplies, and with the prevention of the spread of communicable diseases, and the state is the judge of the qualifications of persons to practise medicine for pay. About one-seventh of the nation's total bill for the prevention of sickness and the care of the sick is now paid by local, state and national taxation.

How much further, if at all, should we extend public

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medical and health services? The issue concerns boundary lines. There are no individualists so rugged as to oppose collective control in every domain; none who want to be left entirely alone; none who demand the right to fight fires each in his own way, to build roads each for himself, to maintain each his own private sewer system, and to protect himself from the Dillingers without interference by the government. Simon-pure collectivists are equally rare. There are none who

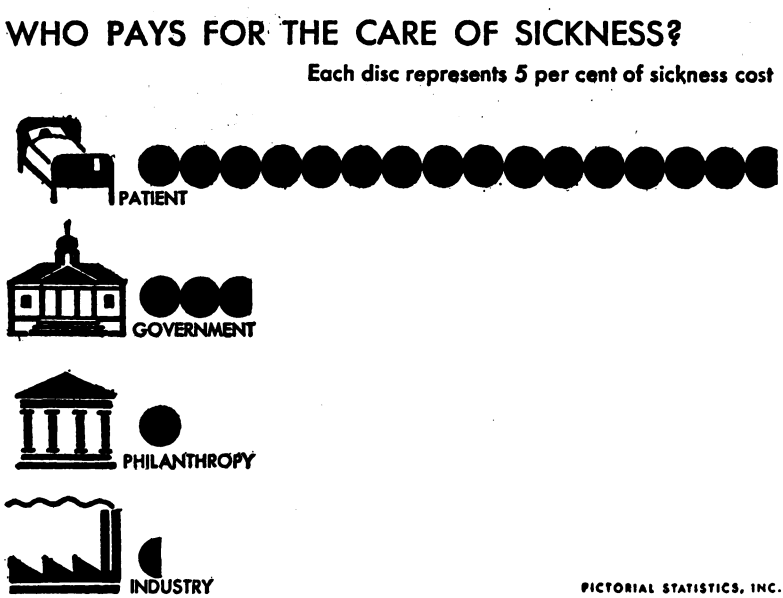


Chart No. 10

renounce laissez-faire so utterly as to insist that organized society shall decide what books they shall read, what they shall eat for breakfast, and what system of bidding—if any—they shall use in contract bridge. Most of the collectivists want to leave the individual alone, insofar as it promotes the common welfare; and all rugged individualists submit a large share of their activities to group control, and like it.

How much further should we go?

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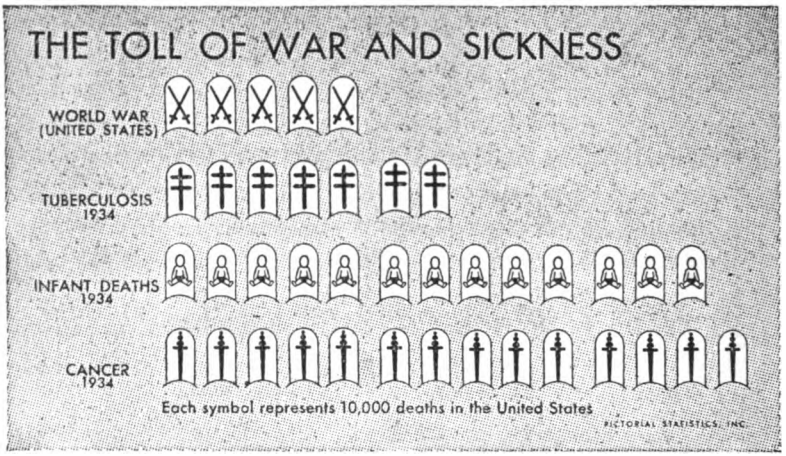


Chart No. 11

Should We Go All the Way?

Those who advocate complete medical and hospital care for all the people at public expense usually state their case in this way:

Medical service provided at public expense can be made as extensive as is desirable. Institutions, personnel and services can be based on the needs of the people, not merely on their purchasing power. Where there are no services today, they can be provided; where they are inadequate today, they can be improved; where they are disorganized or unrelated today, they can be coordinated and correlated; where they are competitive and duplicated, they can become cooperative and economical. The individual's right to medical care is socially recognized and honored; no longer need it be grudgingly given as an act of charity.

Examination, diagnosis, supervision, follow-up and medical records are facilitated. Consultation, medical cooperation and specialism are furthered. Preventive medicine receives much greater attention. Self-diagnosis, self-medication, patent-medicine treatment, and questionable methods of treatment, such as adver-

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tising, quackery, and cults, lose their stranglehold on the people, since medical advice and care is freely and readily obtainable.

The personnel benefits economically, professionally, and in their relations to the public. Unemployment is eliminated by more equitable and economic distribution of services. Incomes are assured. Bookkeeping, charges, collections, disputes, suits, and all the abuses, temptations, and unnecessary unpleasantness inherent in the fee system of today are eliminated, as well as much waste, overhead, and duplication.

A better relationship between patient and profession and between patient and institution results from the removal of the financial "third party." Public interests and professional interests become identical: what benefits one party benefits the other.

The economic security that is inherent in public service; the definite compensation; the permanent tenure of office enforced by civil service law; the security of old age and disability through pension retirement; the regular and orderly conditions and hours of service; the assured opportunities for rest, recreation and travel; the opportunities for advancement, for further professional study, for research, for public education, public health, and preventive medicine, are among advantages of a publicly-supported medical service, which are denied today to most of the professional workers in private service.

These are some of the alleged advantages of complete medical service, available to all citizens at public expense.

What Are the Objections to Complete Care at Public Expense?

The chief dangers of providing free medical care to all persons are often stated in this way:

State administered medicine tends to remove the essentials of a good diagnosis; time, patience and careful attention to details. The administrators of state systems, compelled to watch the costs, emphasize quantity rather than quality of service, and interfere with the sympathetic relation between a skilled physi-

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cian and a cooperating patient. Suspicion on the part of both patient and physician takes the place of mutual confidence.

The management curbs the cost of drugs by restricting the physicians' prescriptions. This adds to the suspicion of the patient who, even if he has confidence in the physician, believes that the physician is prevented by state regulations from prescribing necessary drugs.

The physician who is overtaxed with unimportant consultations or demands for certificates for cash benefits finds little time or inclination to practice preventive medicine, such as immunizations against diseases and periodic health examinations. No system of state-administered medicine has secured as rapid a reduction in morbidity and mortality as has been obtained in the United States under private medical practice.

Quarantine inspection of food and drugs, disposal of sewage, safeguarding water supplies and whatever measures can be applied uniformly to the entire population belong in the field of public health; but when the state undertakes to furnish a complete medical service for all citizens, the result is a lower quality of medical care.

State-administered medicine tends to become a powerful political machine. Political authority is substituted for professional control. The best that can be hoped for is an honest but unprogressive bureaucracy. We have only to observe the results in many states under workmen's compensation and the failure of state and national governments to protect the public against nostrums to forsee the dangers that might follow political control.

This is the gist of the argument often used against complete medical care at public expense.

CONCLUSIONS

1. Health is necessary for the protection of the state; medical and dental care are necessary for the protection of health, and should be obtained in adequate measure by all.

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Any system of medical practice must be judged by the extent to which good medical care actually is afforded to all who need it.

2. In the United States today, poor families and those of medium incomes receive only about half the needed medical care and only about one-quarter the needed dental care.

3. Yet even with the present national income, we *can* afford good care for all our people. Thirty-six dollars a year per person would be enough, if we abolished the reducible wastes of present unbusinesslike methods in the field of medicine. Already we are spending about $30 a year per person. This means that we could give 126 million people the benefits of the astounding advances which have been made during the past generation in medical science, if we spent—and spent to advantage—merely as much money for medical and dental care as we spent, in the darkest days of the depression, for candy, cosmetics, chewing gum, and cigarettes.

4. The chief question is: What method or methods of payment shall we use? The method, however, is only a means to an end. The chief concern is that, wherever possible, service for all shall be provided that will prevent disease, cure the sick and alleviate suffering. The organization to obtain this end is important, but the end is all-important. Toward that end some means must be found of freeing the *science* of medicine from the present chaos and waste of the economics of medicine.

5. The plan of paying each doctor for each service, after the service is rendered, appears to be satisfactory to one-fifth or more of the population. This plan may well be continued for those who like it and are able to pay the bills.

6. To provide good medical care for the rest of the population, there are only three ways: voluntary health insurance, compulsory health insurance, and public medicine. The use of any one of these methods for paying part of the

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bills does not prevent the use of the other methods for paying the rest of the bills.

7. Voluntary health insurance—since this plan was recommended in 1932 by the Committee on the Costs of Medical Care—has been endorsed by the medical profession as a means of pre-paying hospital bills, and already is widely used and declared to be a success. This method of pre-payment on a voluntary insurance basis is now used by numerous groups to provide medical as well as hospital services. Additional experiments, on a non-profit basis, with all the medical services in control of the medical profession, are highly desirable.

8. Voluntary health insurance, however, fails to help that part of the population which is in greatest need of help. For that part, the only sources of help are compulsory health insurance and public medicine.

9. Compulsory health insurance, long tried in Great Britain, is there regarded as a success. Whether it would be equally successful in the United States can be determined only by adequate experiments. If a few states would promptly try various carefully-considered adaptations of the British plan, they might solve the chief part of their present problem. In any case they would render a great public service.

10. Insofar as traditional methods of payment, voluntary health insurance and compulsory health insurance fail to provide all the needed medical care, preventive and curative, which modern science renders possible, the deficiency must be made up by tax-supported services. A case in point is the recent progress of the United States Public Health Service in breaking down the conspiracy of silence regarding syphilis and curbing the ravages of that disease. This is another page in the long history of the gradual assumption by the state of the responsibility for dealing with those scourges which plainly cannot be controlled by private practice.

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Experience, both in the United States and in foreign countries, indicates that the too-rapid extension of public medicine can best be prevented by carefully-considered extensions of both voluntary and compulsory health insurance.

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