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HEALTH CARE FOR AMERICANS

BY C.-E. A. WINSLOW

Can America afford good health care?

Why is our medical care inadequate?

Is State Medicine" wholly bad?

What kind of health program do we need?

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HEALTH CARE FOR AMERICANS

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What Modern Medicine Can Do for Us

In the days of our grandfathers, epidemics of typhoid and typhus fever and diphtheria raged in American cities. The maternity wards and the surgical wards of our hospitals were as deadly as a battlefield. Beginning with aseptic surgery and the identification of the germs of disease, a whole series of discoveries have changed the picture. Anesthesia, the X ray, and radium therapy; chemical and bacteriological blood tests; insulin; and, in the past few years, the sulfa drugs and penicillin have given the doctor new and powerful weapons for the war against disease.

This pamphlet is based on a number of authoritative medical surveys, including *Principles of a Nation-wide Health Program,* the Report of the Health Program Conference (1944); *Medical Care in a National Health Program,* an official statement of the American Public Health Association adopted October 4, 1944; and the Final Report of the Committee on the Costs of Medical Care (1932).

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Today we have more than one million people in the United States whose lives are devoted to the care of the other 135,000,000 of us. They include doctors, health officers, dentists, nurses, pharmacists, and various other types of personnel. We have about 1,400,000 hospital beds at our disposal, and thousands of clinics of various types. We have medical schools, laboratories, and research institutions, more generously supported—and perhaps more ably manned—than anywhere else in the world. The record of our Army and Navy in the care of the wounded and in the protection of our troops in the most fever-ridden regions of the globe is one of the brightest pages in modern history. You and I, and the men who come home from Europe and the Pacific, and their wives and children should enjoy to the same degree the blessings of modern medicine.

But we shall not reap those benefits unless you and I do something about it.

The Lack of Medical Care in the United States

It used to be said that "only the very rich and the very poor receive good medical care." Like most slogans, this is only half true. The very rich do, in general, receive good medical care. The very poor do not, except in the field of hospitalization. Even here, many of them are too self-respecting to avail themselves of care offered only to recipients of charity.

The chart on the next page—based on studies made at the period of our greatest peacetime prosperity, just before the depression of the thirties—shows the inadequacy of the health care received by the one-half of our population with incomes of less than $2,000 a year.*

Later studies, such as the National Health Survey, which covered over two million persons, have amply confirmed these general conclusions. Always and everywhere, we find that families of low and moderate income have more sickness than the well-to-do; and that they receive less medical care.

We can take pride in the triumphs of organized public health during the past half-century. The total death rate from typhoid

*See *Medical Care for the American People*. The Final Report of the Committee on the Costs of Medical Care. University of Chicago Press, 1932.

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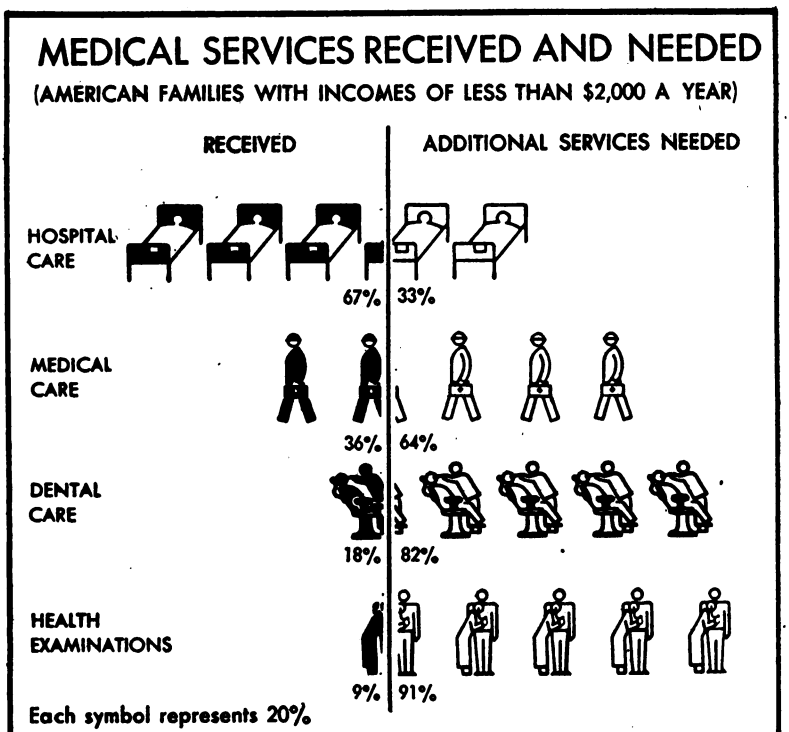
fever, diphtheria, diarrhea, measles, scarlet fever, whooping cough, and tuberculosis decreased more than 86 per cent between 1900 and 1940. This means a saving of over 500,000



lives a year. Yet, in the same period, death rates from all other causes were reduced by less than 22 per cent. It is true that these "other causes" of death are more difficult to control than those which the health officer has so successfully attacked. Yet it can scarcely be doubted that good medical care would postpone death and disability from such causes as heart disease and cancer. To deny such a possibility is to deny the value of medical care.

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The Selective Service examinations give us a rather grim picture of health conditions among our young men. While it is true that many men rejected for military service can make out reasonably well in many fields of civilian life, these examinations have shown that a startling proportion of young men are handicapped by physical defects that could have been corrected by medical advice and treatment. (See the chart on page 17.)

COSTS TOO HIGH

The reason why the fruits of modern medical science have not been made generally available to the American people has already been suggested. The well-to-do have good medical care. The poor, except for hospital care, and the self-supporting families of modest resources do not. The service of the physician is not made available for moderate- and low-income families on conditions which they can or will accept.

The American Public Health Association—representing the public health experts of the United States—recently adopted a statement of policy in regard to medical care in a national health program. In this statement, the association says: "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 basis when they are needed, or because the services are not available."

But, you will ask, "How can this be? Is it not the tradition of the medical profession to give its services free to all who are in need, without reference to ability to pay?" That *is* the tradition of the profession—and a noble one. In practice, however, no such system can operate satisfactorily, however generous the individual doctor may be to the individual patient.

DOCTORS NOT EVENLY DISTRIBUTED

In the first place, the doctors and the dentists and the hospitals are not where the people who most need them can turn to them for aid—even if they would. In one survey it was found that there was one physician for each 1,431 people in South Carolina and one for each 571 people in California. There was one dentist for 5,263 persons in Mississippi and one for 990 persons in Oregon. There was one hospital bed for 749 persons in South

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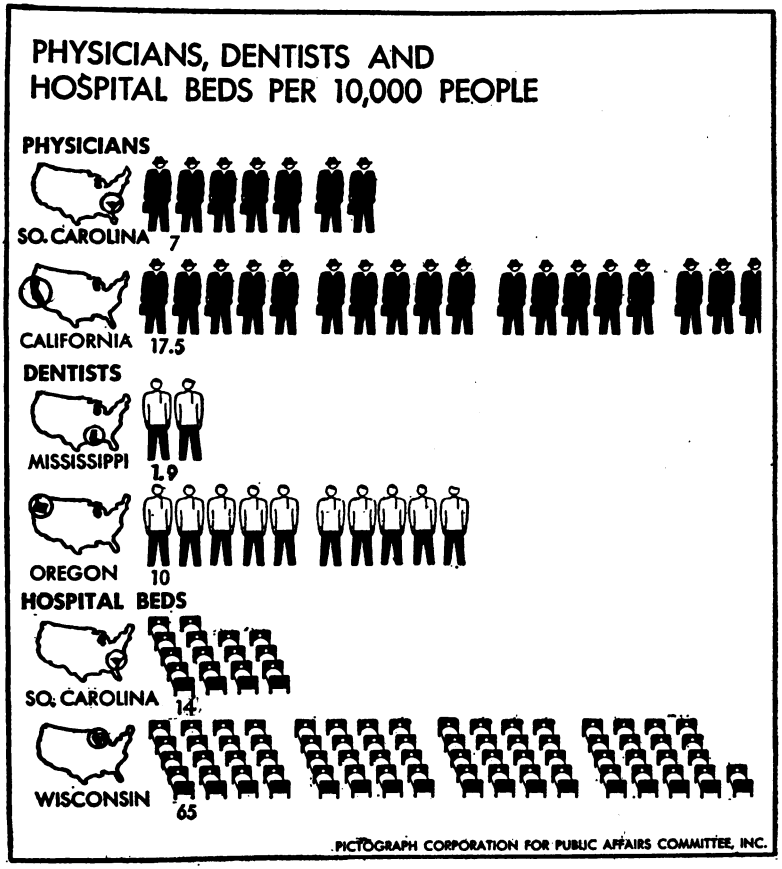
Carolina and one for each 154 in Wisconsin. Why? Simply because South Carolina and Mississippi were, at this time, relatively poor states while California, Oregon, and Wisconsin were rela-



tively rich states. Most doctors and dentists naturally tend to practice where they are likely to be well paid for their efforts.

PRIDE

Even where ample medical care is available, the person of limited means—but self-supporting and independent—will hesi-

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tate a long time before going to a charity clinic or asking his physician for free treatments. Put it to yourself. If you suffer a serious accident or a critical illness, your scruples vanish. But if you have a cut which *may* perhaps heal without infection; if you are conscious of a growth which *might* be cancer; if you have a cough that hangs on which *might* be tuberculosis—do you not put off going to the doctor in the hope that you may not have to incur a bill or ask for charity? Yet it is early medical care which is always most effective.

HEALTH NEEDS DIFFICULT TO BUDGET

You can budget for rent and food and clothing with reasonable accuracy. But medical costs are unpredictable. A particular family in a given year may have very low bills from the doctor, the dentist, and the hospital. Then comes a long illness or a serious operation, and the family may incur crippling debts. In the study of the Committee on the Costs of Medical Care, it was found that in families with incomes under $1,200, one family in a hundred had to meet medical charges of $500 or more in a given year. Many of us who can meet the regular costs of food, clothing, and shelter cannot meet the costs of emergency medical care.

It is no small proportion of the population that is affected. In 1929 far more than half the families in the United States had incomes below $2,000. If we maintain a national income of $100,000,000,000 after the war, 50 per cent of our families would still be in this low-income class; and the burden of medical care is serious far above this income level.

Can the American People Afford Good Medical Care?

Perhaps you may ask whether the American people can buy the medical care they need. Or is medical care a luxury that even our prosperous nation cannot afford?

Good medical care *is* expensive; but not so expensive as that. We know by experience with certain groups of the population that good medical and hospital care can be provided for about $20 a person a year on an average, under a properly organized system of practice. This has been accomplished by well-managed group practice units in many instances, with, at the

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same time, ample remuneration for the physicians concerned. If we add to this sum of $20, $10 more for dental care, we have a total of $30. We could meet this cost if we spent wisely the sum expended during the darkest days of the depression for candy, cosmetics, chewing gum, and cigarettes.

Furthermore, the astonishing fact is that in 1929 we were actually spending about $24 a year a person in the United States for the forms of health care included in the estimate above. We also spent in that year about $6 more for public health, public medical services, and other items not included in these estimates. Therefore, in the postwar world to which we look forward, there can be no question of our ability as a nation to pay our medical bills.

The truth is that before the depression we had nearly enough doctors—though only half enough dentists—to give complete medical care to the American people. We were actually paying out almost enough money to get that care. We were not getting it, however, because of the lack of effective organization of our medical facilities.

BUDGETING THE COST OF HEALTH CARE

WE have pointed out that the cost of medical care differs widely from family to family and from year to year. We face the same problem in connection with other hazards of human life—death, accident, and fire. In such cases, we know the answer. We pool our resources and our risks. We budget these expenses in the same way as food, clothing, and rent. We pay a certain sum each year into a common fund from which the money we need is drawn when the death or the accident or the fire actually occurs. We call this insurance. The risk for your family in a bad year is carried by the contributions of other families that have good years.

Why not apply the same idea to health protection? This would do more than simply spread the costs of care over a group of families and a period of time. It would also help to prevent disease. If you knew that your medical bills were paid, you would turn to the doctor for advice when the first signs of

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disease appeared—dis-*ease* in the sense of lack of vigorous health, efficiency, satisfaction—and not wait until you have to go to bed. Preventive medicine and routine health examinations are only possible under an organized plan of payment. It is useless to talk about them so long as a medical fee is involved in every visit to the doctor. Prepayment really means insurance against disease, not merely against medical bills.

Principles of a Nation-wide Health Program

A group of twenty-nine of the leading experts in the field of medical care recently drew up a report setting forth the "Principles of a Nation-wide Health Program." This group included thirteen physicians (some in private practice, some teachers in medical schools, and others in hospital administration), six economists and authorities on insurance, two labor representatives, and eight administrators of government or voluntary health agencies. For the first time, the outstanding leaders in these related fields met together to discuss the problems of medical care, and their report is the most authoritative yet made on this subject. The report says: "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 budgeted as can other items of expenditures, 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."

The important thing in any plan is that the American people get the preventive and curative care that they need. In fire insurance and life insurance, money alone is involved; and some medical groups have urged that health insurance also should provide only for "cash indemnity." This means that when the

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patient is sick and calls in a doctor or goes to a hospital, the patient may collect from an organization or insurance company some money toward the payment of the bill. The unscrupulous patient, under such a plan, can pocket the money and not pay the doctor at all. The unscrupulous doctor can run up his charges to an unwarranted extent. There is no provision in such a plan for preventive service. The system of "cash indemnity" has been tried again and again and has always and inevitably failed, except where the plan was so restricted that the protection afforded to the patient was inadequate. The only health insurance plans that can work are those in which you pay your money into the fund and the fund pays it to the doctor or hospital; and the ideal plan is one in which you have the right to obtain all the preventive and curative care you need.

The initial programs recently proposed for the improvement of medical care (such as the 1943 draft of the Wagner-Murray-Dingell Bill) cover only hospital and physician's services. Ultimately, dentistry also should be included. Recent studies have shown that the cost of patching up teeth which have suffered from years of neglect is high—averaging $50 or more. Once this end is accomplished, about $10 a year will cover the average cost of dental care for routine maintenance. The average cost of physician's and hospital care, under a well-organized group practice plan, is in the neighborhood of $20 a year. The addition of basic dental care would only raise the total to perhaps $30. These figures do not cover prolonged institutional care of mental diseases and tuberculosis, which is now generally provided at public expense.

It would probably be an economy, and not an added burden, to include in any insurance plan, from the beginning, provision for home nursing on an hourly basis, since such service would substantially reduce hospital costs.

Four Groups of Americans

The pooling of the financial resources of individual families will not by itself solve the problem of medical care for all of us.

Roughly speaking, we may say, for illustrative purposes, that there are four different groups in the population, each with a problem of its own which requires different economic treatment.

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THE WELL-TO-DO

First, there is a group of families with incomes so large that they can pay even the unexpected emergency costs of sickness. We might consider that families with incomes of $4,000 or $5,000 and over would fall in this class. Large families in cities where the cost of living is high will need more income than this; but, in general, those in this economic group, except in cases of prolonged chronic illness, can pay even large medical bills by selling bonds or borrowing on favorable terms. This rather small section of our population can get along under the present fee-for-service plan of buying medical care.

ABOVE AVERAGE INCOME

A second and larger group includes those families who cannot meet the emergency costs of illness without serious hardship but who could pay the average cost under a prepayment plan. Here we may place the families with incomes between $2,000 and $4,000. The limits would be higher for large families and in expensive areas, lower for small families and in areas where prices are low. Except for large families, persons in this group can afford to pay $20 a year into an insurance fund. From such a fund, the costs of completely prepaid medical care, but not dental care, could be drawn if the services were provided by *organized group practice units*. Service by individual physicians on a fee-for-service basis would cost more than twice this sum. This section of our population can pay for its own health protection by some form of insurance combined with group practice.

SELF-SUPPORTING

A third group, still larger, includes, we may assume, families with incomes between $2,000 and the level of dependency. These families—except for small families in low-cost areas—cannot pay even the average cost of medical care. If there are four people, as in the average family, $120 is too large a slice of total income to be allotted to medical and dental care without robbing the members of the family of food and shelter and other essentials. For this group, prepayment by the family alone will not serve. It seems reasonable that the families in this group should contribute within the limit of their means to an insurance fund for

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medical care. But if they are to have really adequate medical care, the amount that they can pay must be supplemented from some other source. For this purpose, plans have been devised for compulsory health insurance. Thus, the law might require every worker employed in certain industries and trades, and every white-collar worker below a certain income level, to contribute to a health insurance fund. Employers share in the contributions (often on a fifty-fifty basis); and the state may add a relatively small subsidy out of tax funds. These latter contributions seem amply justified in view of the interest of the employer and the state in healthy and efficient citizens. Compulsory insurance is the only plan—except complete tax-supported service—which has, in any country, brought the full benefits of medical care to the people who most need such care.

It is by no means necessary, however, that compulsory insurance should be limited to the lower economic groups (say below $2,000). Such a plan would be on a sounder actuarial basis if it included families of higher income who have less sickness and more money to pay for medical care.

THE POOR AND DEPENDENT

Families on relief and large families above the normal relief level but with low cash incomes constitute a fourth group of our population. For this group, health insurance premiums might be paid from public funds so that such families can receive adequate care on a self-respecting basis. The cost to the community would probably be no greater than that of the haphazard medical relief now provided by official and voluntary agencies.

The Blue Cross Plan for Hospital Care

The most important advance toward a more effective distribution of medical costs that has yet been made in the United States is the development of prepaid hospital care. This movement originated at Dallas, Texas, in 1929 and has grown so that more than sixteen million people now enjoy its advantages.

The "Blue Cross Plan," the typical nonprofit plan for prepaid hospital service, works out as follows.* A nonprofit citizens'

*See *The Story of Blue Cross,* by Louis H. Pink, Public Affairs Pamphlet No. 101, 1945.

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organization is formed to act as the insuring agency for a city, a region, or a whole state. This organization enters into a contract with the hospitals of its area to accept patients at fixed daily rates. It enrolls subscribers, usually groups of persons employed in a single place of employment. This precaution is necessary because if single individuals were enrolled at random, the people who are frequently sick would hasten to join and few of those who are rarely sick would join. Enrolment by groups insures a better spread of risks. Each individual who joins pays $8–$10 a year for himself, or $18–$24 for himself and his family. When in need of hospital care he goes to the hospital of his choice and receives, as a rule, three to four weeks of hospital care in semiprivate rooms without fear of cost—since he has already paid the bill.

Although some local Blue Cross Plans are associated with medical society plans that provide surgical care, this is not ordinarily the case. The protection is incomplete. Moreover, this type of prepayment reaches, in general, only the upper- and middle-income levels. Families of low income will rarely feel able to pay out $18–$24 a year to insure against hospital bills alone. Unless this payment is part of a program providing for medical care as well, and unless the contribution is a compulsory one, groups including at least one-third of the population must either go without essential care or mortgage their future income or become objects of charity.

Prepayment for Medical and Dental Care

Arrangements for paying physicians and dentists in a similar way have been worked out much less frequently. It is estimated that perhaps four to five million people in the United States enjoy protection of this type. A recent study of 214 plans for prepayment of medical costs showed that 43 per cent of the persons covered were in groups of industrial workers, 28 per cent in plans offered by medical societies, 15 per cent in private group clinics, 7 per cent in governmental plans, and 5 per cent in programs sponsored by consumer groups. Most of the plans studied give reasonably complete medical coverage, including office consultation and bedside care in home and hospital. The medical society plans (except in Washington and Oregon) are

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much more limited in scope. Of patients insured under such society plans in states other than Oregon and Washington, few have anything like complete protection. Usually medical society plans provide only surgical and obstetrical service in the hospital. Substantial dental care on a prepayment basis appears to be available for only half a million persons.

Thus it appears that the average citizen who desires to pay for medical and dental service on a prepayment basis has almost no opportunity to do so, unless he happens to belong to certain specially favored groups.

Practice in Health Service Plans

Although only about four to five million persons are covered by this arrangement, their experience is of the greatest importance as indicating the lines of possible further progress. The most significant results are those obtained where service is rendered by physicians acting together in a Group Practice Unit.

INDUSTRIAL PLANS

"Group health" plans have been initiated in many different ways. Most of them, as we have seen, have been organized to serve the workers in individual industrial plants. Sometimes, as in the Endicott Johnson Shoe Company at Binghamton, New York, the whole plan is operated and paid for by the employer. In this instance, the service, including all forms of home, office, and hospital care, is available without charge, not only to each worker but to all the members of his family. The cost which the plan involves is considered more than justified by increased contentment and efficiency of the working force. In other cases, as at the works of the Stanacola Company in Louisiana, the program is operated and financed primarily by the workers. More often, employers and employees share in the support of the plan.

PHYSICIANS' PLANS

In other instances, physicians have taken the initiative. The outstanding example is that of the Ross-Loos Clinic in Southern California. This medical group, which included some eighty physicians before the war, served some 70,000 persons, contracting with groups of employed persons to provide relatively

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complete medical and hospital care in return for a regular monthly payment. In Washington, D. C., and Elk City, Oklahoma, there are similar plans sponsored by groups of prospective patients. In most instances, such plans involve the organization of a group of physicians who contract to render service and a group of patients who pay for the service in an orderly, regular fashion.

Well-conducted programs of this sort have given satisfaction to patients and physicians alike; and they have offered striking demonstration of the economy of such cooperative practice. They have clearly shown that complete, high-quality medical and hospital care can be provided through a group program at $20 a year a person, and that physicians and other professional personnel can be well paid under such an arrangement.

If you were fortunate enough to belong to a group of employed persons to whom such a plan was available, some $2 a month would be deducted from your salary and placed in the insurance fund. In an emergency, you would be admitted to the hospital with no financial investigation and would receive the service you need with no worry about bills. You would phone your doctor for home calls, or you would go to his office at the group clinic for treatment with the same freedom from financial anxiety. You would go to him for a health check-up whenever either you or he felt such a check-up to be desirable—again, without the money barriers which ordinarily stand between the doctor and the patient.

ATTITUDE OF THE A.M.A.

Unfortunately, certain groups in the American Medical Association have in the past tried to block the development of plans involving this type of service. They have charged that the doctors sharing in such programs would have an unfair advantage over the rest of the profession—unless the plans were managed by the State Medical Society as a whole. In Washington, D. C. (and in other places) the physicians rendering service to limited groups have been boycotted and expelled from local medical societies. This meant that their patients could not be cared for in hospitals—which usually require that their staffs shall be members of the local medical society. In Washington,

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D. C., this practice brought a prosecution from the Attorney-General of the United States, and after a long legal battle the highest courts decided that such action by a medical society was conspiracy "in restraint of trade" and was illegal.

Compulsory Insurance

Voluntary group payment has made an important contribution to the better distribution of medical costs and of medical care. But if the prospective patient pays the full cost, the benefits are limited to families with incomes sufficient to meet those costs.

In most of the industrial groups receiving medical care under plans which have been described, a part of the costs are actually borne by the employer. This makes it possible to extend good medical care to a wider group of wage earners.

To accomplish such a desirable end on a more comprehensive basis is the objective of compulsory health insurance. This type of insurance has been adopted by some thirty countries throughout the world. England has had such a plan since 1911. Canada is now considering a program of this sort. Details vary widely. In some countries only doctor's service, and not hospital care or surgical and other special types of medical care, has been included; in others, nearly all essential services are provided. In some countries only employed persons are covered; in others, their dependents also. In England, the government has recently proposed a new program providing complete medical care for the whole population. Most industrial workers and salaried employees below a certain level of income have their contributions to the insurance fund deducted from their pay envelopes. The employer also is required to contribute, and in many cases the state pays a subsidy from the general tax funds. Physicians who desire to cooperate are enrolled on a "Panel," from which the insured person selects the doctor of his choice. Doctors are paid in one of three ways: In most instances the physician receives a fixed yearly payment for each patient on his list. In some countries, the physician has, as in the past, been paid on a "fee-for-service" basis—that is, an established fee for each particular service. In a few instances, salaried physicians have been employed by the insurance funds for designated purposes.

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Results Abroad

Compulsory health insurance has generally been successful. Details of organization have been the subject of disagreement; but there has always been a tendency to call for an extension of the kind of service provided and an increase in the number of people to be served. In no country has either the community or the medical profession desired to abandon or reduce the program. The British Medical Association has officially pronounced that "The scheme itself has almost certainly reduced national sickness, and we are quite sure that if the immense gain to national health includes the immense gain to the comfort of the individual in knowing that he can have medical attention whenever he needs it, the gain is most marked."

The results of experience abroad—and of experience with prepayment for special groups at home—is so conclusive that no competent student of the subject doubts the soundness of this general approach. The Health Program Conference declares:

> 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 improvement of facilities. In order that comprehensive service shall be available to all or most of the population and in order to minimize the administrative cost of acquiring members, it is essential that financial participation in the system be required by law.

The conference points out that in view of the frequency with which we Americans move from state to state, of the great differences in financial resources between different states, of the economies of large-scale operation, and of the necessity for adequate standards of service, the program must be a national one and should include all or most of the population without limitations of employment or income.

The 1943 draft of the Wagner-Murray-Dingell bill represents the first specific national program of this kind in America.

Compulsory insurance has been criticized as involving vast new expenditures. Deliberate attempts have been made to confuse the public by giving the impression that the total contributions required under the 1943 Wagner bill cover medical care

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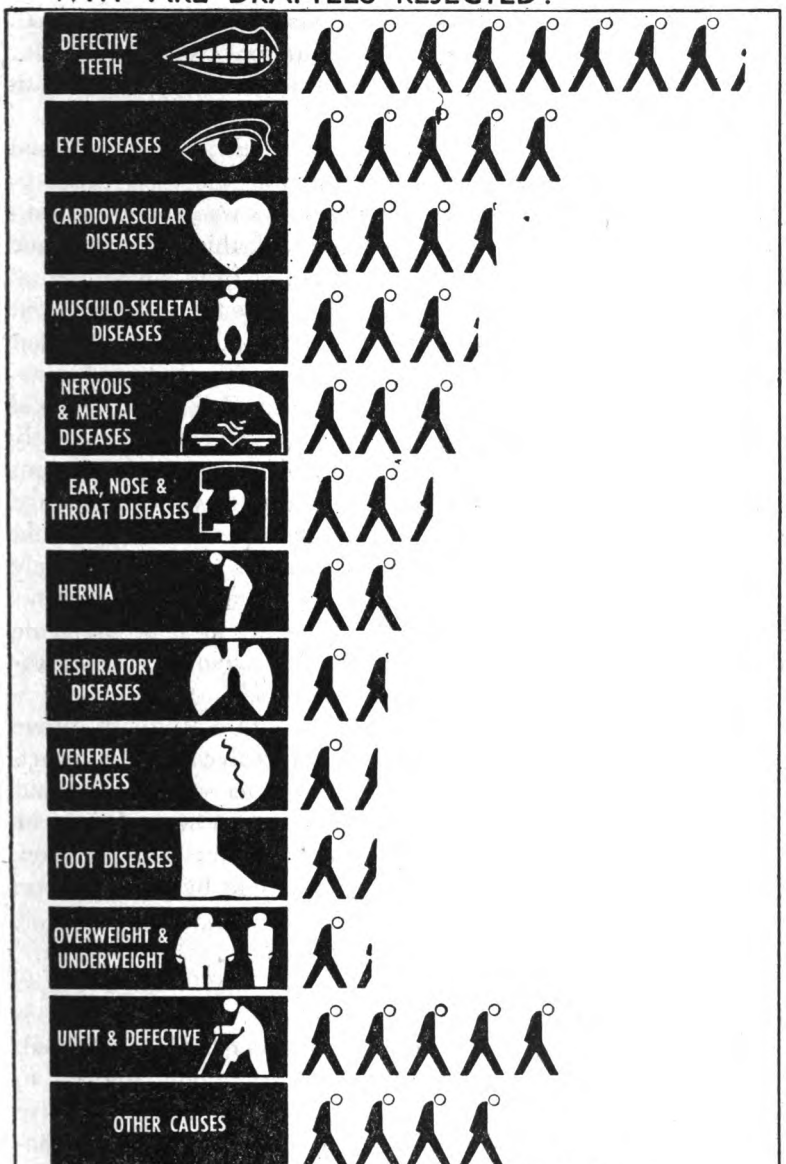
WHY ARE DRAFTEES REJECTED?



Each symbol represents 1% of those medically examined under the Selective Service System (1941)

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alone. Actually, they include the whole program of social security as at present in force and the new benefits to be added. These are: old-age and survivor's insurance, cash benefits for unemployment, permanent and temporary disability, and death benefits as well as hospital care.

I. S. Falk, Director of Research and Statistics of the Social Security Board, reports that before the war the total expenditure for medical services in the United States was about $4,000,000,000 a year. About $3,000,000,000 of this amount came from patients and their families, and the rest from governmental and philanthropic agencies and industry. This represented about 4 per cent of total consumer income. Dr. Falk points out that "Expenditures of no more than these amounts, but under arrangements which assured the widespread availability of medical services, could vastly improve the adequacy of care and greatly advance the public health. If only these amounts were spent, but in such a way as to enable each family to pay an average amount—year in and year out—the burden on consumers would be far less than it has been. These amounts could adequately compensate those who provide the services under arrangements which would assure them of regular incomes and, at the same time, avoid the unconscionable situation of having doctors without patients and sick people without doctors."

Dr. Falk adds, however, that in the future it might prove profitable to increase expenditure for medical care to as much as 6 per cent of the national income. In other words, we could get really good medical care for what we are now spending; or we might decide that even better medical care than we now dream of would be desirable and could be had by paying more.

"STATE MEDICINE"

IN talking about practical problems such as medical care, it is important to use words whose meaning is understood and defined. "Socialized medicine" is the catchword commonly applied to any proposal for improving medical care; but the words have no accepted meaning. They are used merely to arouse emotional resistance and prevent intelligent thought. If anyone asks with a note of horror in his voice, if you believe in "socialized

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medicine," the proper reply is to ask what the speaker means. You will find either that he has no idea what he means or that he is thinking of something very unpleasant which has no relation to any proposals ever made in the United States.

"State medicine," on the other hand, does mean something. It can be defined as health care provided by physicians and allied personnel employed by the public and paid from public funds—city, state, or national. We have a good deal of medical care of this sort. It includes all the medical services provided for the Army and Navy, the veterans, state and county tuberculosis sanatoria and hospitals for mental diseases, city and county hospitals, medical care for the needy, and our entire official public health program. Most of this care is of high standard.

Of course, the Soviet Union goes much farther than this. It regards the health of its people as primarily a governmental responsibility—as we consider education a governmental responsibility. The Soviet Union provides, as a right to all the people, all types of medical care, in home, clinic, and hospital by publicly salaried physicians.

No important group in our own country has approved state medicine in this expanded sense. Most people seem to feel that a comprehensive insurance plan is better suited to our national tradition. Yet either compulsory insurance or state medicine is necessary if medical care is to be provided for all our people.

The government, moreover, would have to contribute to the insurance fund for such families as are unable to make any contribution themselves. Also, in many rural areas, it will be necessary to provide medical care supported directly by public funds if any such care is to be available at all. This is why both the American Public Health Association report and the Health Program Conference report propose a national health service, locally administered, and supported by social insurance and general taxation. Taxes—like insurance—represent merely a pooling of our common resources for a common end.

Public Health Service

Whatever method we use for obtaining the medical care we need as individuals, we shall, of course, require the continuation and expansion of federal, state, and local public health services.

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Our health officers have led in a war against preventable disease that has had amazing results. Much more has yet to be accomplished. There are still 40,000,000 people in this country who live in communities where there are either no local health services at all or where such services are provided only by inexperienced, part-time health officers. Most of these areas spend less than half of the $1 a person a year that is needed to pay for such essentials as collecting vital statistics, providing public health laboratory services, controlling communicable diseases, securing decent sanitation, providing for the hygiene of mothers, infants, and school children, and carrying out a necessary program of health education. At least $2 a person is needed for a really complete program, including necessary public health nursing service. We cannot rest satisfied until every one of our 3,070 counties has an adequate local health service.

The Problem of Medical Facilities and Personnel

The American Public Health Association report emphasizes the lack of hospitals, health centers, and laboratories, particularly in rural sections, in poor urban areas, and in cities where sudden increases in population have occurred. Since there are many counties—and some whole states—which cannot meet the cost of facilities of this kind from their own resources, the need for federal grants-in-aid is obvious. The same lack of funds which prevents hospital construction in our poorer areas also limits the supply of doctors. The poor counties will continue to lack physicians, as well as hospitals, if some financial aid is not provided by the government.

It is for these reasons that Senator Pepper of Florida presented to the Congress early in 1945 a report proposing federal grants to assist in the development of needed hospital and health centers (and also to promote the development of basic public health services, the need for which has been discussed earlier).

The Income of the Physician

Under any national health program the participating physicians, dentists, nurses, and other professional personnel should be well paid. This is essential for the public as well as for the professions in order that service may be of the highest type. The

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training of the physician is the longest and most arduous of any of the major professions, normally requiring four years of college, four years of medical school, and at least a year more of hospital interne service. The health officer must have one or more years of additional training to earn the degree of Master of Public Health or Doctor of Public Health.

In the boom year of 1929, at the peak of peacetime prosperity, the mean net income of all physicians in private practice in the United States was $5,300. This figure, however, was inflated by a few very large incomes. One half of all physicians in private practice earned less than $3,800. For every physician making over $10,000, there were two earning less than $2,500.

The income of the medical profession should be increased and not decreased under an orderly plan of payment. The fee for a particular patient will naturally not be the figure now charged to the patient of large means, but this fee will be paid automatically by all members of the insurance fund and the total income for a given amount of service will be substantially increased. It is more satisfactory to receive a fee of $5 from each of four patients than $10 from one, $5 from another, and nothing at all from the other two.

As stated above, there are three ways in which physicians may be compensated under a prepayment program: payment of a fixed sum for each type of service rendered; payment of a fixed sum a year for each patient served; or a yearly salary. Various combinations of these methods may be used, in accordance with the wishes of the profession in a given locality. The governing principles are stated by the Health Program Conference as follows:

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.

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6. Compensation should, wherever possible, be on a basis not directly related to the amount of service supplied to any individual patient.

It is vital that there should be recognition of exceptional skill and knowledge. It is easier to do this when the physician receives a salary rather than either of the other forms of payment; and compensation by salary is also most favorable to the realization of the fifth and sixth principles set forth above. The salary, however, may be paid by the medical group organized to render service and not by the government.

The Administration of a National Health Program

A national health program such as that outlined above presents serious and difficult problems of administration. The Health Program Conference has declared that as a general principle there should be:

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.

The Social Security Board and the Treasury Department should collect contributions from employers and employees as part of a social security program wider than the one for which the Board and the Treasury are now responsible. Direct grants of federal funds for hospitals, health centers, and basic public health services should continue to be administered by the United States Public Health Service. It is also the logical agency to assume the administrative control of the medical services.

Regional or local offices of the Social Security Board and the Treasury Department will naturally deal with collection of funds from employers and employees (forwarding them to Washington) and with questions of insurance rights and with cash benefits; but State Departments of Health are the natural agencies to handle funds received for medical and health services and to supervise their expenditure under federal directives.

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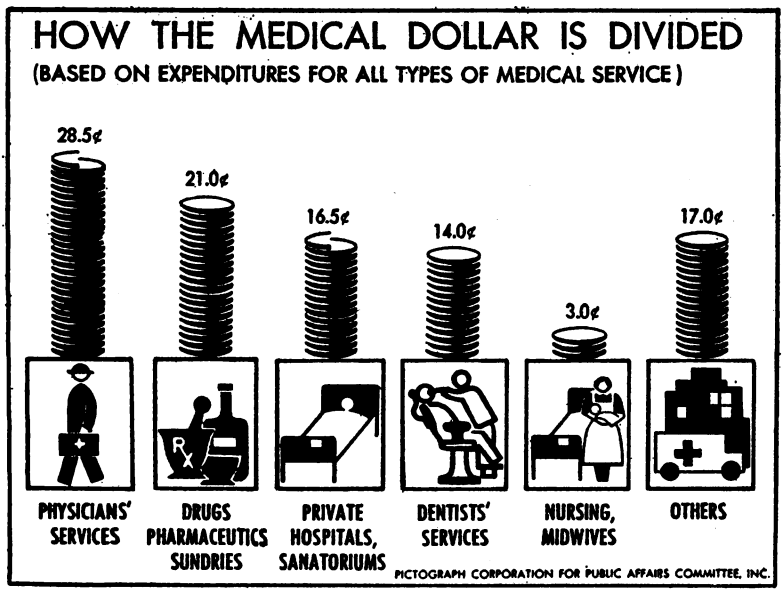
The root of the whole problem lies in administration in the local community. This must be good if the health program is to operate efficiently. Dr. J. W. Mountin says on this point,



"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 Health Program Conference says, "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."

Clearly, there must be constant cooperation between authorities dealing with the financial and with the professional aspects of the program. The professional program of service must be directed by a qualified professional head. The health department seems the ideal place to look for administrative leadership.

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The A.P.H.A. report emphasizes the fact that:

> 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.

Furthermore, the need for relating preventive medicine with the curing of disease is a powerful argument for placing both under the same direction. The local health department should not, of course, manage hospitals or employ physicians to care for the sick except in so far as it now does so. The private practitioner, or a group of private practitioners, would form the keystone of the plan; and all existing public and voluntary hospitals would maintain their identity. The health department should, however, have general responsibility for the overhead administration of the plan, and for securing—under principles laid down by federal and state authority—the protection of the legitimate interests of both physician and patient.

To protect both the public and professional interests, the Health Program Conference points out that:

> 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.

Quality of Service

Medical service is not something which can be measured by the number of physician's visits or the number of days spent in a hospital. Quality is even more important than quantity.

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Under the existing system—or lack of system—we find some physicians and some hospitals applying the very best knowledge of the day in an almost ideal fashion and other hospitals and physicians whose practices are definitely inferior. In rural areas, the same thing is true, except that the proportion of high-quality medical service is less.

Medical societies have earnestly sought to improve this situation; but their power to effect reform is obviously limited. It is in this field that the Health Program Conference has perhaps made its most outstanding contribution. Its report says that:

> 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 personnel service with the greatest economy; and
>
> (e) Provide standards and opportunities for the training of administrative personnel.

The best way to improve the quality of medical care, however, is by the encouragement of group practice. The present situation in medicine is unique among the professions. The lawyer and the engineer habitually work with their professional colleagues in a process of continuing education. The lawyer, too, is responsible to professional judgment in the courts. The clergyman is subject to the criticism of his flock, whose members have

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at least some idea as to what spiritual guidance they need. The physician—if he wishes to do so—can practice for the rest of his life, after receiving his license, without ever being checked up by anyone who knows whether he is doing his job or not. Most physicians *do* read and study, attend medical meetings, and utilize consultants. For those who are not on a hospital staff, or who are on the staff of a hospital which has no real medical organization and is merely a boarding-home for the sick, the process of continued post-graduate education is not an easy one. It is no reproach to a conscientious and learned profession to say that even physicians are human beings; and that all human beings do their work a little better when that work is under the critical eye of a fellow-expert.

We have noted, in an earlier paragraph, that group practice effects notable economies. Even more important is its effect on quality of service, which operates in several different ways:

1. It relieves the physician from clerical and financial responsibilities which involve waste of his special competence.

2. It provides the constant stimulus of contact with his professional peers and of competition on the sound basis of quality of service as judged by those peers.

3. It insures the necessary facilities for good medical practice provided by hospital, health center, and laboratory.

4. It can be utilized to permit special post-graduate training and experience free from the conflicting demands of individual practice.

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.

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.

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THE TWO FREEDOMS

IN all proposals for the prepayment of medical care in the United States it has been recognized that "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."

It is important to emphasize this point because systematic efforts have been made to mislead the American people and to give them the idea that the Wagner bill is a threat to our democracy.

Inflammatory leaflets distributed through the drugstores state that under the Wagner bill the Surgeon-General of the U. S. Public Health Service will have the right "to hire doctors—possibly all doctors—at fixed salaries . . . to designate which doctors can be specialists . . . and to determine arbitrarily what hospitals or clinics may provide service for patients." All this is untrue. The bill merely provides for an orderly system of payment for medical services to be rendered by private physicians in their offices and by specialists and hospitals as now recognized by the existing professional societies.

There is nothing in the Wagner bill, or in any proposal now before the American people, inconsistent with the principle enunciated by the Health Program Conference that "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 service."

It should further be made clear that under any insurance plan, individual patients and individual physicians would be entirely free to contract with each other on the present individual basis if they desired to do so.

The conference points out, for example, that:

> 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

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agents or agencies of service recognized under the law; and to change their sources of service when they so desire, under reasonable regulations.

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.

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.

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 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 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.

The 1943 draft of the Wagner-Murray-Dingell bill did not explicitly include all the safeguards outlined above. They could,

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however, have been added without the slightest change in its fundamental objectives. The sponsors of the Wagner bill rendered a great service in presenting, for the first time, a concrete program for consideration—a program which has stimulated and made possible the recent discussions summarized above.

THE TIME FOR ACTION

IT seems clear that—both logically and psychologically—the time is ripe for action. The people of the United States need and demand the right to good medical care. They can obtain it only through a unified national program with the objective of including complete medical care for all the people.

The A.P.H.A. report puts the case as follows:

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

2. 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.

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

The Health Program Conference states the main issue in similar fashion:

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.

The health service of the future should be comprehensive and coordinated, embracing community health and individual health, prevention and cure.

The conference restates ten principles which should govern such a program:

1. comprehensive coverage and service;

2. spreading of costs;

3. distribution of facilities according to community health requirements;

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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.

In October, 1944, the American Dental Association declared that "dental care should be available to all regardless of income or geographic location"; and that "Dental health is the responsibility of the individual, the family, and the community in that order. When this responsibility, however, is not assumed by the community, it should be assumed by the state and then by the federal government."

The Wagner bill has brought before Congress the basic principle of a national health insurance program—and with suitable modification it can be brought into harmony with all the principles outlined above. The Hill-Burton bill provides for a federally aided plan of hospital and health center development and for an extension of basic public health services.

In California, Governor Earl Warren presented his legislature with a program that would provide prepaid medical care through a system of compulsory health insurance, supported by a 1.5 per cent payroll contribution from employers and an equal amount from employees, and covering all employees with annual incomes up to $3,000.

These are straws in the wind—and highly significant straws. We must remember, however, that the State of California may be large enough and wealthy enough to carry out such a program by itself. North Dakota and Arkansas and many other states are not. It is evident that we need a national program; and that the time for establishing such a program cannot be long delayed.

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For additional facts regarding American health care and other views regarding the organization of such care see:

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