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University of Nebraska Medical Center

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Health Insurance and Medical Care

by

Robert S. Long

Senior Thesis

1940

University of Nebraska

College of Medicine

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Introduction

The subject of health insurance, or sickness insurance if you prefer, was chosen as the subject matter of this paper chiefly because of a firm conviction that it is going to be, in the next few years, the biggest single problem facing men who are now starting out in the practice of medicine. There is not likely to be a great change in basic method of practice which will necessarily affect all members of the profession for a few years yet, but already a great variety of types of practice are available to those men who elect to try them.

More and more, the principle of insurance is coming into play as an economic tool for solving the financial aspect of the problem of medical care. Physicians would do well to inform themselves on this subject, for it is a common topic for discussion in lay journals, newspapers, magazines, and in all social and governmental circles. It is also one of the most common of the non-scientific subjects discussed in the medical and related professional journals. In fact, the available literature on the subject is so voluminous that it was found to be impossible to do more than scratch the surface in the process of accumulating the subject matter of this paper.

Revolutionary changes have been occurring in the social, industrial and political organization of this country during the past decade. These changes have been almost universally in the direction of greater governmental control over industry and society. The

Social Security Act has been in effect for five years. Workmen's Compensation, old age benefits, unemployment insurance, wages and hours regulations, vocational rehabilitation, and maternal and child health care are only a few of the social reforms already with us. Now, it is proposed that the government not only feed, clothe, house, and regulate the work of the "low-income classes", but also furnish them complete medical care, probably through the agency of some insurance scheme.

One of the fundamental difficulties in the problem of supplying medical care today, arises from the fact that we have the medical profession on the one hand with traditions which demand adherence to professional ideals, and society on the other hand organized along commercial and industrial lines demanding that medicine adopt its methods. The problem is to fit medical practice into the society of the day without destroying professional ideals.

An immense amount of study has been done on this problem and many solutions have been proposed by the various groups of "experts" who have undertaken these studies. Invariably, each group--since it is made up of experts, or specialists--has had a different slant on the matter and has overlooked what was common knowledge to one of the other groups. As Dr. Hugh Cabot points out in his book, "The Doctor's Bill," the economist errs upon the side of simplification. He tries to reduce the problem to cold facts and figures, overlooking the fact that medical practice deals with personalities and people not always quite up to the niceties of balanced logic and

theoretical economics. The expert in social science has been likely to approach the whole problem from the side of poverty. He has been impressed by the results of poverty, and wishes to obtain a more satisfactory distribution of medical care entirely through the gateway of the relief of poverty. The physician obviously sees the problem from an entirely different viewpoint, too often from a prejudiced one. Physicians have a very real vested interest which it would not be human in them to disregard. Often enough in their opposition to change, they have failed to grasp the implications of the profound economic and social changes which have been going on about them. Finally, there is the controlling interest of the public, who certainly cannot avoid being profoundly affected regardless of what happens. In today's commercialized world, it is difficult for the average man to grasp the process of mind which lies behind the bill which he receives for medical services. He cannot see why he should have to pay more than did his friend, Jones, for what appears to him to be the same article. He cannot grasp the intricacies of the sliding scale in medical fees--and indeed he is in good company.

There is scarcely any material on the subject of the various aspects of the medical care problem that is not in the nature of special pleading. The reader is therefore cautioned that the material found in the various sections of this paper is prejudiced according to its source.

There can be no doubt as to the fact of the existence of a

medical care problem. Many physicians, especially younger ones, have insufficient practice to earn a decent living; one-third of the hospital beds are empty most of the year; thousands of nurses are unemployed. Meanwhile, millions suffer and tens of thousands die from ailments which might be cured or alleviated by medical aid. Both professional and lay groups have been complainants against the status quo. Both have had sufficient cause, but neither has understood the true underlying reason for the difficulties.

It is the purpose of this paper to try to present, first, the nature of some of the problems encountered in the administration of general medical care, and, second, to present some of the proposed solutions to these problems with brief constructive criticisms of each.

The material presented on the cost and distribution of medical care and the cost of drugs and medicines is taken largely from work done by the Committee on the Costs of Medical Care during the period 1928 to 1932, but these figures have been verified by more recent work, such as the National Health Survey, and are certainly not too old to be of considerable significance and accurracy.

The section on the background of health insurance has been made very brief, largely because a recent paper has dealt extensively with this aspect of the subject. This paper is rather concerned primarily with recent experiments and ideas about applying the health insurance principle to the problem of medical care.

A special discussion is given on the National Health Conference

of 1938, for this event impressed the writer most strongly as signifying the opening gun for a renewal and extension of the battle of the social reformers to apply their principles to evolving a solution for some of the medical care problems, whether organized medicine likes it or not.

A summary of the National Health Program, as proposed by the National Government Administration and endorsed by various "social" groups, is given in order to indicate the lines future legislation is likely to follow.

During the past decade several thousand plans for the distribution of general medical care have been introduced in various parts of the country by various lay and professional groups. Many of these, of course, were discarded soon after their inception, but several hundred are still in existence today. An attempt was made to reduce these to a relatively few basic types of plans, and about twenty such are described in this paper in order to show what types of solutions are now being experimented with in an effort to solve some of the medical care problems.

The role of commercial health insurance in financing present medical care needs is discussed. A description of types of contracts, their scope, and their cost is given. The criticisms of commercial health insurance offered are those of the writer. The material found in this section of the paper was obtained from sample policies, charts, and other literature furnished by one of the largest commercial health and accident insurance companies in the world, and also from many conversations with officers and underwriters of several insurance companies.

One of the bombshells which can precipitate a hot argument in any group discussion is whether or not this country should institute a system of compulsory health insurance. Accordingly, a special discussion of the arguments for and against compulsory health insurance is given.

Since physicians would be the group most affected by any change from the present method of administering general medical care, their side of the story is presented fairly completely. The source of material for this discussion was largely "official" publications of the American Medical Association. The attitude of organized medicine towards health insurance is given, and also some representative "plans" or solutions offered by them.

Finally, the conclusions offered are entirely those of the author, and represent a brief summary of the final impressions left after reading the source material and constructing the body of the paper.

Thanks and appreciation are hereby extended to Dr. C. W. M. Poynter and Dr. E. L. McQuiddy for their kindly counsel and direction in the preparation of this paper.

The Cost and Distribution of Medical Care

Before proceeding with a discussion of health insurance, or any plan devised to equalize the costs and facilitate the distribution of general medical care, it seems necessary to point out first the nature and extent of distribution of medical care under the present system, its cost, and some of its defects.

The findings of the Committee on the Costs of Medical Care, although they are now nearly ten years old, are still accepted as a standard in the field of medical economics. They were entirely substantiated by the findings of the more recent, but less extensive, National Health Survey, conducted by the United States Public Health Service. The material in the following paragraphs is taken almost entirely from the publications of this Committee.

The Committee on the Costs of Medical Care was organized at a conference in Washington, May 17, 1927, (at the time of the annual meeting of the American Medical Association) which was attended by some sixty representative physicians, health officers, social scientists, and representatives of the public. After an extensive study, a five-year program of research, consisting of seventeen studies, was adopted on February 13, 1928. The work of the Committee was made possible through the financial support of eight "Foundations."

First, as to the costs of medical care. The Committee foun d that in 1929, the total national medical bill was $3,656,000,000.00, or $30.08 per capita. Of this amount, 2.9 billions consisted of

patients' fees and other direct expenditures (thus reducing the actual per capita outlay to about $25.00), 510 millions came from government through tax funds, 182 millions represented voluntary contributions, and 79 millions were expenditures by industry. Further, the Committee found that $1,090,000,000, or roughly one-third or $10.00 per capita, went to physicians in private practice in the form of fees; 866 millions went into construction, maintenance, and operation of hospitals; 715 millions were spent for drugs and medicines; and, 445 millions went to private dentists. Thus, four items account for 3.06 billions out of the 3.66 billions total.

As to the distribution of medical care, the Committee found that, although there was substantially the same incidence of illness per family or per individual in the various broad income groups, families with incomes under $1200 to $2000 received far less medical service than those with incomes of $5000 or over. The Committee admitted data from United States Public Health Service Reports showing that, when groups with incomes under $1500 or $2000 are further subdivided, a definite relation appears between poverty and illness, the lower income groups having more illnesses and illnesses of longer duration. It also pointed out that families with incomes of $1200 to $2000 received even less hospitalization and preventive services than did families with incomes under $1200. Further, in spite of the large volume of free work done, and in spite of the sliding scale of charges, nearly one-half of the individuals in the lowest income group received no professional, medical or dental attention of any kind,

curative or preventive, and an average for all income groups was 38.2 per cent who received no medical, dental, or eye care. The Committee's survey did not include data for negroes, who constitute 10 per cent of our population with probably even more serious health problems than the whites.

The Committee concludes that the 360 millions spent for "patent medicines," the 125 millions spent for the services of osteopaths, chiropractors, naturopaths, faith healers, and allied groups, and possibly even greater sums spent for inferior services of some licensed physicians and dentists, are almost entirely wasted. This amount, in itself, would go a long way towards giving adequate service to those 38 per cent of people who get no medical care of any kind.

As to the distribution of costs of medical care, the Committee found that 80 per cent of the families studied, who had charges of less than $60.00 per family, incurred only 31 per cent of the total bill for this entire income group, while the 3.5 per cent with charges of $250.00 or over per family also incurred 31 per cent. In other words, less than 4 per cent of the families collectively incurred as much charges as 80 per cent incurred collectively. One of the most significant of all the Committee's findings was this one: That costs of medical care in any one year fell very unevenly upon different families in the same income and population groups. The heart of the problem, therefore, is the equalizing of the financial impact of sickness. The individual family derives no comfort from the knowledge

that the average cost of medical care is not excessive for families with the average income. The unpredictable nature of sickness and the wide range of professional charges for nominally similar services, render budgeting for medical care on an individual family basis impracticable and impossible for 99 per cent of families. The answer then becomes obvious--spread the costs evenly over large groups of people over periods of time--in other words apply the insurance principle.

An important factor in causing costs to be borne unequally is hospital care. For example, it was found that, in the experience of families in the $2000 to $3000 income group, living in cities of 100,000 or over population, those who used any hospital service in connection with illness had average total medical charges for the year of $261.00, while those who had no hospital care reported total charges of only $67.00. For families with incomes under $1200, the average hospitalized illness cost $67.00, while families with incomes over $10,000 were charged $470.00 for the average hospitalized illness. Further, illnesses which involved hospitalization were found to be responsible for 50 per cent of the total charges for medical care. It seems, then, that hospital insurance alone would answer at least a part of the medical care problem, and this factor is discussed fully in another part of the paper.

Another serious problem, according to the Committee, is the precariousness of the incomes of a large majority of physicians, dentists, and other professional personnel. When practitioners'

incomes drop, they do so in part because the people are not purchasing even the customary ammount of service, and in part because the physician is being asked to carry individually the community's burden of charitable medical service. Neither of these conditions should be tolerated.

One of the worst results of the present method of remunerating physicians is that practitioners may have, or may be thought to have, an economic incentive to create unnecessary medical service or to prolong illness or to perform unnecessary operations. Some necessary operations are performed by surgeons who are selected because of size of the rebate which they will secretly give to the referring family practitioner. "Fee-splitting," although condemned by the medical profession, has arisen, in part, because of the unjust difference, in many cases, between the fee of a general practitioner or internist and the fee of a specialist. While fee-splitting tends to overcome this inequality, it increases the costs of medical care, degrades the profession, puts the patient, in effect, in the hands of the highest bidder, and weakens the incentive for skillful and careful work on the part of the specialist. Physicians' incomes are not only precarious, but also less evenly distributed than in comparable professions. This is suggested by the fact that the average net income of physicians in 1929 was $5300, but the median or middle income was only $3800. Further, one-third of all private practitioners had net incomes of less than $2500. The contrast is even greater between general practitioners and specialists, the former averaging under $4000 and the latter over $10,000. The average income

for rural practitioners is less than one-half as large as the average for the metropolitan physicians.

Just as bad off as the physicians are the hospitals. The community insists that hospitals should keep up to date in equipment and facilities, and at the same time should not raise charges to a point which works hardship, so non-government hospitals face a real crisis. An average of a least a third of their beds are empty; requests for free service have greatly increased; income from private philanthropy and community funds has been seriously reduced; hospitals are not able to pass on any appreciable percentage of the costs of free work to the well-to-do patients; and, expenses cannot be reduced enough to meet these difficulties without impairment of service--hospital employees are already the most grossly underpaid of all workers. Governmental hospitals have increased in number, in quality of service, and in the proportion of beds occupied, but customarily do not serve the very people who, through taxes, contribute most to their support.

As to drugs and medicines, the 715 millions spent annually, for the most part with retail druggists and merchants, compares with the total earnings of physicians or hospitals. These expenditures, however, have not aroused the same complaints as have the costs of physicians' services and of hospitalization. The reasons are that the expenditures for medicines are more fully predictable as to time and amount, are relatively uniform among individuals, are frequently avoidable in part or in total, and, above all, are

made in small amounts. The patent medicine maker is "the poor man's doctor." The total annual average per capita expenditure for drugs and medicines is roughly $5.50, not much less than what is spent for physicians services. Poor people, spending under $10.00 a year total for medical care, spend 66 per cent of the total for medicines, people spending $10.00 to $24.00 total spend 41.7 per cent for medicines, people spending $25.00 to $49.00 total spend 26.3 per cent for medicines, people spending $50.00 to $90.00 total spend 17 per cent for medicines, and people spending over $1000 total spend 2.6 per cent for medicines.

As to the cost of complete medical care, the Committee concludes that it could be provided, excluding capital charges, for $20.00 to $40.00 per capita per annum, if services were organized economically and efficiently and sold to representative groups of the population among whom there is not an abnormally high rate of sickness. Included in this care would be the services of physicians, dentists, and other personnel, and the provision of hospitalization, laboratory service, X-ray, drugs, eye-glasses, appliances, and other items. This estimate of cost is based not only upon a theoretical computation of the amount of service necessary to meet the people's real needs and the cost of providing it, but also upon the experience of various organizations that are now providing complete or nearly complete service for advance weekly or monthly fees. Low-income families, however, usually cannot pay an annual cost of even $20.00 to $40.00 per capita. A family of five with an income of $1500.00

for example, would have to spend $100 to $200, or 7 to 13 per cent of its income to pay for such service. Anyone familiar with the budgets of families in this income group knows that such an expenditure for medical service would entail severe hardship. As has been pointed out, however, an annual cost of $30.00, or even $40.00 per capita, is well within the collective resources of the country, so some method of tapping the combined resources of the population must be found.

The Committee found that the needs which should be met, in general terms, are the following:

a. The people need a larger volume of medical service than they now utilize.

b. Modern public health services need to be extended to a far greater percentage of the people, particularly in rural areas, towns, and small cities.

c. There is need for a geographical distribution of practitioners and agencies which more closely approximates the medical requirements of the people.

d. In the rural and semi-rural areas, the expenditures for medical care are insufficient to even approximate adequate service or provide adequate remuneration to the practitioners.

e. There should be an opportunity for many practitioners to earn larger net incomes than they now receive. This is particularly true of well-trained recent graduates, who frequently must practice five to ten years before they attain an adequate income. The incomes

of general practitioners and of specialists should be more nearly equal than at present, and the opportunity and incentive for "fee-splitting" should be removed.

f. There needs to be better control over the quality of medical service, and opportunities should be provided for improving quality as rapidly in the future as it has been in the past. Practice by unqualified "cult" practitioners should be eliminated. The practice of specialties should be restricted to those with special training and ability; more opportunity for post-graduate study should be available for physicians; and, there should be constant chances for physicians to exchange experiences and assist each other.

g. There should be more effective control over the number and type of practitioners trained, and their training should be adjusted so that it will prepare them to serve the true needs of the people.

h. There is need for reduction of waste in many different directions, such as on unnecessary medication, on the services of poorly qualified or utterly unqualified "cultists", in the idle time of physicians, dentists, and nurses, in the high "overhead" of private practice, in unused hospital accommodations, and in the time of patients who go from place to place seeking medical service. Misdirected expenditures, competition, and excessive specialization among practitoners, and the absence of community planning and of integration of services and facilities contribute to extensive waste.

i. The prevailing methods of purchasing medical care have

unsatisfactory consequences. They lead to unwise and undirected expenditures, to unequal and unpredictable financial burdens for the individual and the family, to neglect of health and of illness, to inadequate expenditures for medical care, and often to inequable remuneration of practitioners. There needs to be some plan whereby the unequal and sometimes crushing burden of medical expenses can be distributed.

The essentials of a satisfactory medical program which will meet the above needs are:

1. The plan must safeguard the quality of medical service and preserve the essential personal relation between patient and physician.

2. It must provide for the future development of preventive and therapeutic services in such kinds and amounts as will meet the needs of substantially all the people, and not merely their present effective demands.

3. It must provide services on financial terms which the people can and will meet, without undue hardship, either through individual or collective resources.

4. There should be a full application of existing knowledge to the prevention of disease, so that all medical practice will be permeated with the concept of prevention. The program must therefore include not only medical care of the individual and the family, but also a well-organized and adequately-supported public health program.

5. The basic plan should include provisions for assisting and guiding patients in the selection of competent practitioners and suitable facilities for medical care.

6. Adequate assured payment must be provided to the individuals and agencies which furnish the care.

The general lines of approach to obtain a satisfactory medical service which will meet at least most of the needs and conditions outlined above, according to the Committee, are (1) the development of types of organized or group practice that will effectively and economically meet the community's needs, (2) the distribution, over a period of time and over a group of families or individuals, of the costs of service--in other words, insurance and/or taxation, and, (3) provision for the planning and coordination, on a local and regional basis, of all health and medical services. The advantages and disadvantages of group practice are many, and space will not be given to enumerate them here. Group practice on a non-profit high-standard basis in association with a hospital is certainly not a completely unsatisfactory solution to a large part of the problem.

As to insurance, wage-earners evince more interest in financial protection against loss of wages due to illness than in the provision of medical care. Extensive studies of the foreign systems and of some local American plans, have convinced the Committee that serious difficulties arise when the administration of cash benefits is united with the provision of medical care. There must be a clear-cut separation between insurance to meet the costs of medical care and insurance

to cover a portion of the wage loss due to illness. It would not be advantageous to extend the principle of Workmen's Compensation in such a way as to cover diseases in general, since it would place the whole financial responsibility on industry, unemployment would suspend medical care, and employees and their physicians would be too directly dependent upon employers.

As for taxation, tax funds now meet about 14 per cent of the annual medical bill, the major outlay being for hospital service. Most writers are agreed that tax funds must support most of the _hospital_ care of persons with mental disease, tuberculosis, and other communicable diseases, and all work of health departments such as milk and water supply inspection, sanitation measures, etc. The same is true of the care of military and naval personnel, of inmates of prisons and other wards of the state, and of the so-called "indigent" persons. Taxation is peculiarly necessary where there are wide divergences in the financial resources of different localities. The primary responsibility is local, but where local funds are insufficient, supplementary aid should be given from, preferably, the next larger government unit.

Planning and coordination of service in each community separately and in all communities collectively is an essential part of the reorganization needed in the administration of medical care. There should be an agency in each community through which the lay and professional groups concerned in providing and financing medical services could consult, plan, and act in behalf of the best provision

of medical resources which the community can afford. In the metropolitan areas, the principal problem is not geographical but functional; namely, to break down the institutionalism and the sectionalism of groups which waste effort and money and leave some areas uncovered. In sparsely settled areas, the need is for more financial resources and increased linkage with physicians and hospitals of other communities.

An actual plan modeled on the above data is suggested by the Committee on the Costs of Medical Care in which a key, non-profit "community medical center" is developed in every city of approximately 15,000 or more which will offer complete medical care as outlined above. Nearly all practicing physicians and dentists in the area, according to the plan, would be on the staff of the single center. A few physicians and dentists would undoubtedly prefer to continue indefinitely in individual practice. The staff members would be remunerated on a salary basis. Any surplus personnel would be shifted by the state coordinating board to a location where their services were needed. Certain specialists might serve as consultants to several centers on monthly retainer fees. Within the medical center, the role of the family practitioner would be prominent and respected. Each patient would be primarily under the care of the family practitioner of his choice, and would receive attention from specialists only when referred to them. In metropolitan areas, several such centers would exist according to the population. In

smaller towns, several places might combine to support a community medical center or a smaller unit would be established, which would possess sufficient facilities to care for the majority of medical cases. This unit would be an affiliated branch of a more fully equipped center in the nearest city to which obscure or difficult cases could be sent or from which consultants could be called. In the villages and rural areas a series of "medical stations" would be strategically located. Each would be under the supervision of a complete medical center, or nearest affiliated branch, and would consist of one or two physicians, a dentist, and a few public health nurses. The development of these medical centers, branches, and stations can and should come as a natural evolution of existing organizations in the medical field, according to the Committee. The work of medical centers would be coordinated with industrial organizations, governmental care of tuberculous, and mental cases, official and unofficial public health agencies, and with those individuals still in private practice. The total costs of this system would not exceed the estimate given in an earlier paragraph, and would be met by (1) insurance paid for in full by individuals or families, with or without aid from their employers, (2) by the use of tax funds, local, state, or both, or, (3) by a combination of insurance and taxation as suggested previously. Practitioners would be compensated according to figures given in an earlier paragraph, and their average income would be somewhat greater than it is now.

The reader should bear in mind that the Committee does not

advocate that this plan could or should be put into effect overnight, but should be the result of slow, gradual evolution and change. It is simply an objective at which to point. This plan was approved by the majority of the Committee on the Costs of Medical Care, but was violently criticized by the minority groups. The minority report recommends "that the corporate practice of medicine be vigorously and persistently opposed; that methods be given careful trial which can be rightly fitted into present institutions and agencies; and, that government activity and competition in the practice of medicine be restricted to the care of the indigent, the hospital care of tuberculous and mental cases, the support of the medical departments of the Army, Navy, and Coast and Geodetic Survey, the promotion of public health, and the care of veterans suffering from bona fide service—connected disabilities and diseases."

The majority recommendations of the Committee on the Costs of Medical Care are numerous and detailed, and not all are pertinent to the subject matter of this paper, but a few of the more important ones deserve at least a mention because the five-year study of this reputable Committee is certainly a landmark in the field of medical economics, and furnishes a reason for the application of the insurance principle to medical care. The influence of the findings and conclusions of this Committee is seen in practically all published material, lay and professional, which has come out since the Committee published its report in 1932-33.

1. The Committee recommends that medical service, both preventive and therapeutic, should be furnished largely by organized groups of physicians and allied professional persons, preferably in the form of medical centers outlined above.

2. The Committee recommends the extension of all basic public health services, with reference primarily to those now performed by health departments.

3. The Committee recommends that the costs of medical care be placed on a group payment basis, through the use of insurance or taxation or both, with the individual fee basis remaining for those who prefer it. Compensation for wage-loss due to illness should be separate and distinct from medical services.

a. Organized groups of consumers (industrial, fraternal, educational, or other reasonably cohesive groups) should unite in paying into a common fund from which organized groups of medical practitioners would be paid for service.

b. The industrial states, at least, should immediately begin to plan for the adoption of legislation which will require all persons in certain income groups, certain occupations, or certain areas, to subscribe for health insurance. Tax funds should be used to help pay the low-income families' share.

c. Rural areas, or those of low economic resources, should subsidize or employ salaried physicians to furnish general medical care to all the residents, and should also provide for hospital and other allied services. State and federal tax funds should supplement local funds where necessary.

d. In the absence of a more comprehensive plan, there should be furnished a voluntary hospital insurance plah, tax funds for local hospital care and general medical care of the indigent, instead of the entire load falling upon the charitable agencies and physicians as at present, and public support for the care of chronic diseases, including tuberculosis, mental disease, and arthritis, and public responsibility for the care of venereal disease.

4. The Committee makes several recommendations in the field of professional education, particularly for an increased emphasis on the teaching of health and the prevention of disease, better education of dental students, pharmacy students, and nurses, and opportunities for systematic training of hospital and clinic administrators.

So much for the findings and recommendations of the Committee on the Costs of Medical Care as to the costs and distribution of medical care. The more obvious defects in the present system of administering general medical care are well summarized by the following findings of the National Health Survey, which agree, in general, with the findings of the Committee:

1. 50 million Americans are in families receiving less than $1000 a year income.

2. Illness and death increase their toll sharply as income goes down; medical care decreases sharply as need for it mounts.

3. Gross sickness and mortality rates of the poor of our large cities are as high today as they were for the nation as a whole a century ago.

4. No physicians care is received in 28 per cent of seriously disabling illnesses among normally self-sustaining families just above the relief level.

5. In the case of disabling illness, lasting a week or more, one out of four receives no medical care among 20 million people in the relief groups.

6. Over 40 per cent of counties in the United States do not contain a registered general hospital to serve their total of 17 million people.

7. Only five states have two or more beds per annual tuberculosis death--the ratio required by clinical experience.

8. 40 out of 49 state health officers report that facilities for maternal care are inadequate.

9. In 1936, a quarter of a million women had no physician's care at time of delivery.

10. For the majority of the million births attended each year in the home by a physician, there is no nurse to care for mother and child.

11. Two-thirds of our rural areas are without child health

centers or clinics.

12. Less than one in twenty now receive pneumonia serum, when it could easily reduce the present mortality by 25 per cent.

13. Thirty thousand lives a year could be saved by more adequate provision for early diagnosis and treatment of cancer.

14. Every year 70 million sick persons lose over one billion days from work.

15. Health supervision is inadequate in most industrial plants employing five hundred or less workers; representing 62 per cent of the population.

16. Self-supporting families with incomes up to $5000 spen d an average of 4 to 5 per cent of their budgets on medical care; but "unpredictable serious illness may descend upon them with catastrophic force and wipe out their earnings and savings--the economic independence of the family itself."

17. In the $1200 to $2000 income group, 5 per cent of families bear 32 per cent of total costs of illness falling upon this group; 26 per cent bear 44 pe r cent of the costs; 69 per cent bear 24 per cent of the costs. This irregular and unequal incidence of sickness is one of the most compelling arguments for health insurance.

In the face of the above findings, Dr. Olin West, Secretary and General Manager of the American Medical Association, has been widely quoted as saying: "There is not one human being of my acquaintance in the United States, nor, in my opinion, has there ever been, who could not get adequate medical care if he had enough initiative to ask for it," and this opinion has been echoed by other prominent officials of organized medicine.

Background of the Health Insurance Idea

The most remote background of all American thought along the lines of the public's health and what to do about it, chiefly in the form of some kind of health insurance with which we are here mainly concerned, lies in Europe. As the European background of health insurance has been extensively discussed in a previous paper and as some mention will be made of it again in later pages, we can dispose of it in short order here.

Germany has had compulsory health insurance since 1883, at which time industrial sick benefits and medical care plans operating in the German mining and railroad industries were systematized and extended to cover a very large percentage of the population. These benefits are now supported by payments from employees and employers and administered under state supervision by local organisations in which both groups are represented. They provide for medical, cash disability, maternity, and funeral benefits. It is difficult for a thinking American to accept any form or detail of government legislation in effect in a totalitarian state such as Germany, but the remarkable beauties of compulsory health insurance as in practice in many other countries, including Germany, are emphasized and extolled by proponents of compulsory health insurance.

Great Britain's compulsory health insurance act was put through Parliament in 1911 in spite of the opposition of the British Medical Society, which has since changed to a position heartily in favor of

the act, according to American proponets of compulsory health insurance. The British act makes no provision for the care of dependents or for funeral benefits, specialists, consultants, or dental care. The intricate panel system of English medicine, as practiced today, is probably well understood by very few American physicians, let alone laymen, but is most frequently used as the proposed pattern by American proponets of compulsory health insurance. The attitude of organized medicine toward this particular system will be discussed in some detail in subsequent pages, as it has an important bearing on the attitude of very many practitioners toward compulsory health insurance in America.

Many other countries, some twenty-five, with a population of 500,000,000, have compulsory systems of health insurance for all or part of their workers. The only major nations remaining without any compulsory health insurance provisions are China, India, and the United States.

In American, the compulsory health insurance idea first became publicly expressed in 1915. The particular organization behind the movement initiated at that time was The American Association for Labor Legislation, and let us pause briefly here to remark upon the myriad of organizations which have existed in America for the past thirty years, and which have increased in number so greatly in the past few years as to stagger the imagination of any thinking person who reads even a few publications of whatever nature. There is absolutely no way of knowing the particular interests, motivating

forces, or even personnel of more than a relatively insignificant few of these groups, so that when we read that some pressure group or other with a long name spelled in capital letters is agitating for some reform or other, let us remember that they are talking with a special pleading, and take what they say with a large grain of salt. Even their name is seldom indicative of their general purpose in society. At any rate, this particular group, some twenty-five years ago, conducted a campaign which resulted in the appointment of eleven state commissions to study the subject of compulsory health insurance, and of these commissions, a majority of six urged the enactment of a compulsory health insurance program.

The California Commission declared that "legislative provision for a statewide system of compulsory health insurance for wage workers and other persons of small incomes would offer a very powerful remedy for the problems of sickness and dependency in the state of California. ..Any legislation on this subject should provide: (a) for a compulsory system....by non-profit making insurance carriers, (b) for a thoroughly adequate provision for the care and treatment of the sick, (c) for contributions from the insured, from industry, and from the state." Other state commissions reported in a similar vein.

Of course, we do not know exactly who was on these commissions, who appointed them, or what their (or their bosses') interests were. Their terms are certainly very general, yet they were careful to limit the suggestion for compulsory health insurance to "wage workers and other persons of small incomes." They also allowed the state

to contribute its money to a greater or lesser extent without giving it a very great voice in the control or direct management, leaving it rather in the hands of "non-profit insurance carriers", and this the state would certainly not do, for wherever and whenever the state disburses any very large amount of money, it always attaches many strings to it for usually quite adequate control, as perhaps it should.

In 1919, Governor Al Smith told the New York Legislature that he strongly urged the enactment of a health insurance law because he believed that the incapacity of the wage-earner due to illness was one of the underlying causes of poverty, and that such a bill would result in greater precautions being taken to prevent illness and disease, and thus eliminate the consequent waste to the state therefrom. The New York bill was patterned after the German scheme in that it included a provision for funeral insurance, so it was fought, not only by the American Medical Association and the great industrial life insurance companies, but also, strangely enough, by the American Federation of Labor. We might mention here in passing that the new health program presented by the federal government at the National Health Conference is strongly supported by the American Federation of Labor, the Congress for Industrial Organization, and the large life insurance companies--notably, the Metropolitan Life Insurance Company, the largest in the world.

During the period, 1920-32, the incomes of both patients an d doctors were apparently high enough so that scant attention was paid

to the little agitation exhibited for health insurance programs, although the Committee on the Costs of Medical Care did report the existence of a huge volume of unmet medical need, and went so far as to endorse voluntary health insurance as a possible solution. The million-dollar study of this imposing Committee was terminated in 1932, and not continued, largely because of opposition expressed in certain quarters of organized medicine, as exemplified by an editorial the Journal of the American Medical Association of December, 1932, published.

Four of the Foundations, namely, the Milbank Fund, the Twentieth Century Fund, the Rosenwald Fund, and the Pollack Foundation, continued to work in the field of medical economics, however, and were rather severely criticized by the official medical press. In fact, the Milbank Fund was the object of a particularly bitter attack in 1934 and 1935, because its directors advocated a form of compulsory health insurance and because of its previous activities in Cattaraugus County, N. Y., where it had spent many hundreds of thousands of dollars in a social experiment in the form of an organized attack upon disease from the standpoint of prevention, and more particularly upon infant and maternal mortality, tuberculosis, typhoid, and diphtheria. Apparently, a few physicians opposed this interference with their practice, although the Milbank Fund sought persistently to cooperate with the local medical society as evidenced by grants of fellowships and direct reimbursements to the physicians. These physicians believed that "the drift toward paternalism and

pauperization is very strong; the tendency toward socialization of medicine is openly avowed by many supporters of the Milbank group...and our medical society can do nothing else than protest... against such quackery." So vicious became opposition to the Milbank Fund, that a boycott of Borden products boiled up in 1934 because of the fact that Albert G. Milbank was President of the Milbank Fund and Chairman of the Board of the Borden Company, in which 45 per cent of the Milbank Fund's capital was invested. This boycott was particularly active in Indiana, in Bronx County, New York, in Philadelphia, in Detroit, and in many other cities and counties, with many bitter articles being published in various medical journals and bulletins. The Milbank Fund finally did an about face in 1935, and friendly relations were again formed between organized medicine and the Milbank Fund.

A great deal more could be written about this and other controversies, much of it with small credit to organized medicine, although there are, of course, two sides to the story, but enough has been said to indicate the nature and extent of the opposition of organized medicine to various advocates of health insurance plans.

This opposition became even more strenuous in 1934, following the President's first Social Security speech, in which security against sickness was clearly envisaged as an essential part of the contemplated program, and was strong enough to make impossible the inclusion of health insurance in the Social Security Act. At this time, the House of Delegates of the American Medical Association

passed its famous ten-point statement against both compulsory health insurance and any development of voluntary health insurance initiated outside the control of organized medicine.

There was also much scattered opposition within organized medicine to various group practice clinics and group prepayment enterprises embodying the health insurance principle, such as the Ross-Loos Clinic in Los Angeles and the Medical Center in Chicago. Some of these plans will be discussed in more detail later as examples of various ideas developed by physicians and others to attempt to meet the various medical needs presented in various communities.

After failure of the administration to get "sickness security" into the Social Security Act in 1934, a program of medical relief was attempted through the Federal Emergency Relief Administration (precursor of the Works Progress Administration) in 1935, under which private physicians were paid by the relief authorities, at a mutually agreed upon scale, for their services to relief patients. But so huge was the need that in none of the twenty-six states which adopted this program were the available funds sufficient to provide anything like what was needed. However, this experience did form the basis for the National Health Survey later conducted by the United States Public Health Service.

Later, in 1938, another government agency, the Farm Security Administration, attempted to solve the medical care problem in rural areas by a plan of voluntary (?) health insurance arrangements. This plan will also be discussed in more detail later.

At about this same time, the American Association for Social Security, (another group of axe-grinders) got a model (?) health insurance bill introduced into Congress (the Capper Bill) and several state legislatures. This was later more or less abandoned in favor of Senator Robert Wagner's Health Bill for the latter individual apparently carried a great deal more weight in National politics and was willing and anxious to exert it.

Also, at this time, the American Hospital Association came out flat-footedly in favor of group hospitalization; a plan really started several years earlier and which is discussed fully in subsequent pages.

In 1936, the American Foundation compiled under the directorship of Miss Esther Everett Lape, an allegedly off the record survey of medical opinion on social health questions, the result of which was published in 1937 in two volumes entitled "American Medicine." The results of this survey were interpreted by proponents of compulsory health insurance as indicating that the American Medical Association had ceased to represent the interests and opinion of medical leadership in this country. This survey did bring together some famous physicians, such as Dr. Hugh Cabot, Dr. Milton Winternitz, Dr. John Peters, and others, who later formed the nucleus of the famous Committee of Physicians for the Improvement of Medical Care, which openly opposed the attitude of the American Medical Association in general policies regarding social health insurance and methods of widespread application of medical care. The American

Foundation disclaims having had any part in the formation or sponsoring of this Committee. The well-known "Principles and Proposals", promulgated by this Committee, will be discussed later. It is sufficient to note here only that there were some physicians and not all infamous ones, at this time who were sympathetic with the theories of the new national health program. Soon after this, a survey by the American Institute of Public Opinion purported to show that a majority of American doctors favored the principle of health insurance.

The presentation of the background of the health insurance movement has been necessarily brief in order to make room for more important and significant material regarding the whole problem of health insurance in this country. It is intended to serve only to set the stage for the discussion of the National Health Conference, which marks the beginning of a real battle to see how far into the business of medicine the government can get.

The National Health Conference

The National Health Conference took place in Washington on July 18-20, 1938. The delegates and observers included Thomas Parran, Surgeon-General of the United States; Dr. Irving Abell, President of the American Medical Association; Dr. Olin West, Secretary and General Manager of the American Medical Association; Dr. Morris Fishbein, Editor of the Journal of the American Medical Association; Dr. Hugh Cabot and Dr. John P. Peters of the Committee of Physicians; assorted representatives of the American Federation of Labor, the Committee for Industrial Organization, the American Farm Bureau Federation, the Farmers' Union, the National Parent-Teachers Association, the League of Women Voters, the Medical Bureau of the Cooperative League of the United States, the American Association of Social Workers, the Press, the Radio, and Business, and was presided over by Miss Josephine Roche, Chairman of the President's Inter-Departmental Committee to Coordinate Health and Welfare Activities. There were also present many members of the large Technical Committee on Medical Care. It is worth noting here, that the whole show was staged by the National Government Administration; nearly all the time was taken up by members of the Government Committee in giving their reports and analyses and propaganda; the audience and "delegates" were certainly well hand-picked individuals and groups who had their own axes to grind, and the few representatives of _organized_ medicine were given only short periods to present

their side of the story, and they were not fore-warned before the Conference started as to just what was going to be presented.

The President, in his message to the Conference, definitely stated his belief that it was the ultimate responsibility of the Government for the health of its citizens, and emphasized the responsible role of the public in regulating the doctor-patient relationship. His justification for a national program of action was the fact that millions of citizens lacked the individual means to pay for adequate medical care, and that the economic loss due to sickness was a "very serious matter", not only for many families with and without incomes, but for the nation as a whole.

Surgeon-General Thomas Parran, Jr., addressed the Conference, and as his remarks are especially blunt and significant, he will be more or less directly quoted, briefly, in the following paragraphs.

"It is my firm belief that this Conference marks the ridge of the hill between the old indifference to health as a matter of national concern and a new understanding that health is the first and most appropriate object for national action. People are beginning to take it for granted that an equal opportunity for health is a basic American right. They are thinking a little ahead of the law-makers, and, I fear, ahead of the practitioners of public health and clinical medicine. It has been the insistence of the people back home that has pushed through both houses of Congress, without a dissenting vote, our recent legislation for cancer and venereal

diseases. It is not unlikely that public health may be the next great social issue in this country.

"We need to provide medical care for the treatment of disease and the relief of suffering among those groups of the population who unaided cannot provide such care for themselves. We should not continue to think in terms of the separateness of public, private, and voluntary efforts, or of the separateness of preventive or curative efforts to reduce death and disease. All are parts of the same entity. It is our job to make them mesh.

"It is true that if the economists could show us how to produce and distribute an income equal for the health and needs of every family, the need for many public health measures would be minimized. The inter-relationship between poverty and disease is well known. Disease begets poverty, and poverty, in turn, creates more disease. At the present time, however, our proven ability to prevent disease exceeds greatly our proven ability to control other causes of poverty. Economics are still in the Hippocratic-stage of development. It has not yet had its Pasteur, its Koch, or its Lister. Medicine and public health, therefore, should lead economics rather than follow it. The application of preventive medicine offers the best opportunity to interrupt the downward spiral which I have described--to tear out the roots of poverty and the consequences of ignorance by attacking the most readily preventable factor. It is tragic that our health departments are better supported in time of prosperity, when our need is least than when depressions

come and our need is greatest."

Here is an excellent speech on economic and social theory delivered by a medical man. Proponents of the National Health Program interpret it as a great contribution to their cause, and so it is. But, again, it presents largely only one side of the story and leaves the other half implied, but unsaid. Of course, disease begets poverty and poverty begets disease, but no thinking person, including Dr. Parran, really believes that the application of a health program, however perfect it is in scope and application, is the panacea for our health _and_ economic problems. They must be worked out coincidentally and simultaneously. All physicians know that by far the largest part of the health problems of the relief, unemployed, and low-income families are the _direct_ result of poor housing, poor food, poor clothes, poor nourishment, _and_ ignorance. What avail to cure them of pneumonia, a vitamin deficiency, or what not this week, when they will have the same thing next week because the same direct cause is still there? The medical profession cannot nurse, feed, clothe, and house their patients.

The address of Dr. Irving Abell, President of the American Medical Association, followed Dr. Parran's talk the first day of the Conference. He did state that "our own studies have revealed certain local inadequacies and certain inequalities in the distribution of medical care", an admission quite in contrast to the previous position of the American Medical Association, which had

been to the effect that there was no important volume of unmet medical care except in cases where patients failed to seek out available physicians. He referred significantly to the "Ten Commandments" adopted by the House of Delegates of the American Medical Association in 1934. They will be presented later, but state in substance that all features of medical service must be controlled by the medical profession, the immediate cost must be paid so far as possible by the patient directly, and systems for the relief of low-income classes should be limited strictly to those below the "comfort level" standard of incomes.

Dr. Abell also questioned some of the Government's statistics, especially as regards availability of hospital service. He stated that the Council on Medical Education and Hospitals of the American Medical Association had found that there were only thirteen counties in the United States more than thirty miles distant from an acceptable general hospital, and in eight of these counties there were less than five people per square mile of territory. As the average county is only twenty miles square, and as the Government speakers referred to "registered general hospitals", and Dr. Abell to "acceptable general hospitals," both could perhaps be perfectly correct.

The next group of speakers were the representatives of the various organizations mentioned previously. They were all well-drilled and each told his own little story about the troubles of his own group, then asked for extension of money and hospital and other facilities to his area--the labor union leaders to the industrial

areas, the farm groups to the rural areas. Most of them spoke in very general terms and did not reveal the source of the various figures which they used, such as that "....four-fifths of the rural areas of the United States lack any organized health service."

The last of the Administration's speakers on the first day of the Conference turned out to be Dr. Hugh Cabot, Chief Consulting Surgeon of the famous Mayo Clinic, and one of the chief promoters of the Committee of Physicians. Dr. Cabot's speech was exceedingly well written, with traces of humor, much common every-day logic, and resounding emphasis on certain significant points. He opened by remarking that surveys had been made regularly since before 1492, and he suggested that "we get this survey business over and get on with the war." As Dr. Abell criticized some government figures, so did Dr. Cabot criticize American Medical Association figures in his statement that "I am not clear by what method physicians are to know about people whom they never see; the people who get no medicale care obviously don't crowd the doctors' offices; and precisely how they are to arrive at figures which will be more convincing, if perchance, we meed any figures that are more convincing, is beyond the limits of my slow mind." Dr. Cabot continued in the same vein with the result that he linked his wing of the medical profession with the social workers and government forces; he discredited in advance any attempt of organized medicine to win delay while they compiled their own studies on medical care and need; he expressed contempt at a "do nothing" policy, because our death rate is relatively low; he pointed up the anomaly of the situation in which young

doctors starve for years while doctorless patients die; he agreed that the consumers (patients) are entitled to a large word in determining doctor-patient relationship; and, he even declared that the medical profession was incapable of keeping up its own standards and that therefore the government must do so. His closing remark is especially apt and is here quoted directly: "Medicine is a competitive business. Many of us have the gravest difficulties in reconciling competition with the ideal which we are all taught, and many of us even, at my age, continue to believe, is the basis of the profession. We remember as long as we remember anything, the fact that medical service sprang out from the church, as did all great services of the community. Now is it possible in a highly commercialized environment to maintain a service organization on a competitive basis? If someone will answer me that one, I will be his slave for life."

The second day of the Conference was taken up by the reports of the members of the Technical Committee on Medical Care, and here, we find the crux of the Administration's solution to what they believe the problem of medical care to be in this country. They are necessarily couched in rather general terms, and the underlying philosophy is that the states and local communities should serve as the administrative agencies, the role of the federal government being to contribute technical and coordinating services, together with financial aid proportioned to the need of a given community on the one hand, and its ability to pay on the other. The Technical

Committee's recommendations recognized that present systems cannot be scrapped, and they make far-sighted provisions for the coordination, integration, and redistribution of the existing personnel and institutional machinery of the health services, as well as their planned expansion through the stimulus of federal tax subsidies.

Before giving a summary of the National Health Program, which will be expressed in fairly general terms, a few lines will be given on what the Administration proposes to do about each of some of the common health problems and diseases so familiar to all physicians, so that the reader may have a little more concrete idea about at least some phases of the proposed program. The figures given are the Technical Committee's.

> Tuberculosis: 420,000 Americans suffer from active tuberculosis; 70,000 die of it annually, and a million more are exposed to the infection. Both theoretically and practically, tuberculosis can be eradicated almost completely. Recommended: A program of case finding, expansion of clinic service and early hospitalization. Costs: Annually $43,000,000 from all sources.

> Pneumonia; The present mortality of 150,000 annually could easily be reduced by 25 per cent by making laboratory diagnosis and serum therapy generally available. Recommended: Annual expenditure of $22,000,000 (all sources) divided fifty-fifty between the purchase of serums for the needy, and the support of laboratories, nursing, and other field services.

> Cancer: General application of present methods permits promise of saving 30,000 lives annually. Recommended: Setting up diagnostic and treatment centers accessible to all people in each state, present provision being "totally inadequate." Costs: $25,000,000 annually from all sources.

> Malaria: Now localized in Mississippi delta and certain

southeastern states but not declining appreciably in those areas. Recommended: Establishment of "malaria units" in state and local health departments of malarious areas, with a program of elimination of mosquitoes and clinical care of malaria "carriers." Cost: $10,000,000 annually from all sources.

Mental Hygiene: A half a million mental cases are now confined in institutions; more than half a million psychotics are at large. Recommended: Enlargement of public institutional facilities for the mentally ill and defective; these to be used as centers for the development of a program of diagnosis, treatment, and mental hygiene education. Costs: $10,000,000 annually over and above costs of building new institutions.

Industrial Hygiene: Concerns the health of 15,000,000 people, over half of whom work in small plants inadequately provided with health services. Recommended: Extension of present program established under the Social Security Act, in which industrial hygiene units have already been set up in twenty-one states. Costs: $20,000,000 annually.

Venereal Diseases: 518,000 new syphilis cases and 1,037,000 new gonorrhea cases seek treatment annually; these figures probably grossly understated the amount of recent infection. There are 60,000 cases of congenital syphilis annually. In addition to direct mortality, syphilis is a secondary cause of 50,000 deaths annually, and accounts for at least 10 per cent of first admissions to hospitals for mental disease. Recommended: Gradual increase of present program of clinic care and casefinding until annual expenditure of $50,000,000 is reached.

Public Health Organization; The Committee recommends the addition of $23,000,000 to the amounts now available from federal, state, and local sources; to be expended largely for providing full-time health officers, epidemiologists, public health nurses, sanitary engineers, sanitarians, laboratory technicians, and other personnel.

Maternal and Child Health: Our maternal death rate has declined only slightly over the past twenty-two years. Physicians estimate that from one-half to

two-thirds of maternal deaths are preventable; that the still-birth rate can be reduced by 40 per cent; and, that the deaths of newborn infants can be reduced by at least one-third. Thirteen million of the 35 million children under fifteen years of age in the United States are in families with incomes of less than $800 a year, or on relief--which means that, lacking public aid, these families can do little to safeguard the health of nearly half of the oncoming generation. The Committee recommends a gradual increase of the present federal subsidy, starting with an additional expenditure of $4,500,000 the first year and reaching $47,500,000 by the tenth year; this subsidy to be matched by state and local funds. The program provides for expansion along present lines, of maternal and infant medical and nursing care, and the wider extension of diagnostic, consultative, and hospital services. In addition, $2,000,000 is to be added to the present $2,800,000 available under the Social Security Act for the care of crippled children; this added federal subsidy to be increased to $5,000,000 by the fifth year.

Hospital Facilities: The Committee reported that 1338 counties in the United States, containing 17,000,000 people, are without a registered general hospital and that hospitals are concentrated in the metropolitan centers, and distributed according to the ability of the population to pay rather than according to actual need. Tax-supported hospitals are overcrowded; hospitals dependent upon pay patients are partly empty. The Committee does recommend wider use of existing hospital and outpatient facilities and also new construction and wider extension of services through government subsidies to the tune of $552,000,000 over a ten-year period, to be matched by local appropriations. This includes the buildings for tuberculosis, diagnostic centers, and mental institutions. Temporary grants of $177,000,000 (distributed over ten years, and here is the first mention of a most important item) for maintenance purposes is also recommended.

Medical Care for the Medically Needy: The Committee estimates that the minimum medical needs of the

medically needy could be met a cost of $10.00 a person. There are 40,000,000 of such persons living in families with annual incomes of less than $800. The Committee recommends federal grants-in-aid, starting with $50,000,000 and finally reaching $200,000,000 annually, the states supplying the other half of the needed total. Further, the Committee states that if the federal government undertakes, as it must, to subsidize medical care for the medically needy, it must accept responsibility for the maintenance of medical standards--with everything that this responsibility for the maintenance of medical standards entails.

Public Medicine and /or Health Insurance: In this section the Committee attempts to synthesize its earlier recommendations, for the expansion of public health service, hospital and clinic facilities, and the provision of medical care for the medically indigent, with alternative and coordinate recommendations for the distribution of medical care to the self-supporting groups. The two pillars of the argument for health insurance are; first, that families with incomes of under $1200 a year suffer more sickness and lose at least twice as much working time because of sickness, than well-to-do families; second, that no family with an income of less than $3000 a year can afford to pay individually, on a fee-for-service basis, the costs of medical care.

The Committee estimates that the present cost of adequate medical care, as defined by competent professional judgment, and excluding the costs of community services, dentistry, medicines, or appliances would be about $76.00 per person per year, or about $310 per year for an average-sized family. With group purchase of medical care, they estimate that as good medical care can be purchased on a voluntary basis for $17.50 per person per year; or, adding $7.50 per person annually for dental service, the cost becomes $100.00 per year for the average family. Even this amount is twice the average sum now spent by families at the $1000 income level, and one-third more than by families at the $1500 level. Hence, the Committee concludes: "If medical care is to be made available to all families with small

incomes at costs they can afford, the costs must be spread among groups of people and over periods of time." In other words, we must have health insurance, and, moreover, it must be compulsory health insurance covering all employed workers below the $3000 a year income level, and with provision for the inclusion of persons without income through contributions on their behalf from public funds.

The Committee states that voluntary health insurance "has nowhere shown the possibility of reaching more than a small fraction of those who need its protection." As to costs, the Committee says that "the overall cost of services to be furnished through health insurance or analogous public medical services, or both, may be estimated to be about $2,600,000,000 a year total, or $20.00 per person." Federal participation is estimated at one-fifth to one-third of the total and it is suggested that a start be made with an appropriation of $52,000,000 to $82,000,000. Since present expenditures for the private purchase of medical care average about $20.00 per person per year, the Committee is concerned with new and better methods of making current expenditures more effective than in increasing the amount of the expenditures.

Disability Insurance: The Committee recommends both temporary and permanent sickness disability compensation. The first cost would be about 1 per cent of wages to provide benefits up to 50 per cent of wages for a period of twenty-six weeks. Permanent disability insurance with benefits geared to old-age benefits would cost 0.1 to 0.2 per cent of wages at the outset and would rise to 2 or 3 per cent in the course of twenty or thirty years.

The Committee emphasizes that if a program of public medicine, plus health insurance, were accepted, many of the recommendations and appropriations for particular diseases and social classes as noted briefly above would not be necessary.

After the presentation of the Technical Committee's report as briefly outlined above, Dr. Olin West again took the platform on behalf of organized medicine. He wisely presented the following criticisms

of the report:

1. That it would not be a wise thing to project such far-reaching policies on the basis of conditions that exists in such an artificial situation as that in which we find ourselves today;

2. That some of the figures presented in the reports were not in accordance with the facts;

3. That the creation of a great system of sickness insurance, no matter how it started, would eventually be a system controlled politically;

4. That there would be great danger to the health of this nation through the centralization of control of medical service by any state agency;

5. That a subsidized system of medical care, erected on the foundations of a chaotic and declining total national economy, would be to some degree a house built on sand, even though a sound structure of medical care is a necessary part of the new foundations; and even though it may be both proper and necessary for health engineers to lead the economists, rather than follow them.

The third day of the Conference was given over to the spokesmen for organized medicine. The most important speaker was, of course, Dr. Morris Fishbein, Editor of the powerful Journal of the American Medical Association, and what he had to say was most significant, for he has long been the recognized spokesman for organized medicine.

In opening, Dr. Fishbein, reiterated what Dr. West had previously pointed out; namely, that a program planned in the light of conditions in this country during the past ten years could not be a far-reaching program planned for a nation which is to go forward during the ten years to come. He maintained that the <u>first</u> problem for this government was to relieve the conditions under which one-third of the people were poorly clad, badly housed, and undernourished,

and that medical care was not the most important problem before the people of the United States today. Continued Dr. Fishbein, "And so we come here--the medical profession--called to a conference on a national health program, and I leave it to you whether or not we have been called to a conference or whether the patient whom you represent has not asked the medical profession to write a prescription for Radway's Ready Relief, which the patient has written and wants the medical profession to sign so he can get the prescription filled. That is not scientific medicine, and that is not scientific economics. Who has even mentioned here the manner by which this extensive program is to be integrated into our American civilization? What is to happen to our insurance companies which we have already established, to the sickness plans of the Moose and the Eagles and the Masons and the Odd Fellows and the Elks and all of those people who have put a great deal of their own money into their own institutions and sanatoria, to the hospital plans which have been so carefully built and now embrace more than two and a half million people, and to the non-profit voluntary hospitals built by the Catholics and Jews and Methodists and Presbyterians and all other religions, who out of their faith, which makes the care of the sick a fundamental duty of mankind, have built these institutions and given of their services to the American people?"

Dr. S. S. Goldwater, Commissioner of the Department of Hospitals of New York City, brought the conference down to earth by pointing out that the objectives were commendable, but that the

program arrived at its results by methods of calculation that were too simple to be reliable. "Neglected illness," he said, "is not always convertible by means of money grants or administrative measures into illness effectively prevented or cared for. A substantial fraction of increased government expenditure is almost certain to be used for more custodial care, another large fraction is likely to be absorbed by the simple substitution of paid for unpaid medical service, and still more for liberalizing conditions of employment for nurses and other institutional personnel." Dr. Goldwater further pointed out that great caution was required in dealing with private agencies that conduct mixed services for rich and poor, without clear accounting methods and that, while social-economic conditions affected health, logically, all influences injurious to health should be attacked in a balanced, comprehensive program.

Dr. Robert P. Fischelis, Secretary of the New Jersey State Board of Pharmacy, called attention to another great defect in the projected program; namely; that the production and distribution of drugs and medicines had received little or no attention in the deliberations of the Conference, or in the proposed National Health Program. He pointed out that although drugs with specific therapeutic value or rational bases for use in the treatment of disease were few in number--less than one thousand having received official approval in the United States Pharmacopoeia, the National Formulary and New and Non-Official Remedies--upward of fifty thousand proprietary "ready-made" medicines were listed in the drug trade lists and

included preparations sold directly to the public without medical advice as well as so-called "ethical proprietaries" prescribed by doctors.

The rest of the National Health Conference was made up of spokesmen for various groups already mentioned, who, for the most part gave unqualified endorsement of the program recommended.

So much for the National Health Conference, undoubtedly the most significant single event in present day medical-social economics. It put the handwriting plainly on the wall as to what the social theorists and organized pressure groups expected to do to the American medical system. At the risk of some slight repetition, the official summary of the program recommended by the Technical Committee on Medical Care to the Inter-Departmental Committee to Coordinate Health and Welfare Activities, and presented to the President February 14, 1938, will be presented as the next section of this paper.

The National Health Program

The Technical Committee's study of health and medical services in the United States indicates that deficiencies in the present health services fall into four broad categories.

1. Preventative health services for the nation as a whole are grossly insufficient.

2. Hospital and other institutional facilities are inadequate in many communities, especially in the rural areas, and financial support for hospital care and for professional services in hospitals are both insufficient and precarious, especially for services to people who cannot pay the costs of the care they need.

3. One-third of the population, including persons with or without income, is receiving inadequate or no medical service.

4. An even larger fraction of the population suffers from economic burdens created by illness.

The Committee submits a program of five recommendations for meeting with reasonable adequacy existing deficiencies in the Nation's health services. Estimates of the total additional annual costs to federal, state and local governments of Recommendations I, II, and II are also submitted. The Committee does not suggest that it is practicable to put into effect immediately the maximum recommendations. It contemplates a gradual expansion along well planned lines with a view to achieving operation on a full scale within ten years. Except insofar as they overlap and include portions of the first three recommendations, Recommenda-

tions IV and V involve chiefly a revision of present methods of making certain expenditures, rather than an increase in these expenditures.

Recommendation I: Expansion of Public Health and Maternal and Child Health Services.

The Committee recommends the expansion of existing cooperative programs under Title VI (Public Health Services) and Title V (Maternal and Child Health Services) of the Social Security Act.

A. Expansion of General Public Health Services (Title VI): Fundamental to an expanding program of preventative health services is the strengthening and extension of organized public health services in the states and in local communities. It is recommended that federal participation in the existing cooperative program should be increased with a view toward equalizing the provision of general public health services throughout the nation. The Committee further recommends that increasing federal participation be utilized to promote a frontal attack on certain important causes of sickness and death for the control of which public health possesses effective weapons.

The Committee tentatively estimates that, at its peak, an adequate program of expanded public health service would require additional annual expenditures by federal, state and local government of $200,000,000 for these purposes: Strengthening of public health organization; the eradication of tuberculosis, venereal diseases and malaria; the control of mortality from pneumonia and

and industrial hygiene. The Committee recommends that approximately one-half of these increased funds be provided by the government.

B. Expansion of Maternal and Child Health Services (Title V): Included in this part of the recommended program are provisions for medical and nursing care of mothers and their newborn infants; medical care of children; services for crippled children; consultation services of specialists; and more adequate provisions for the postgraduate training of professional personnel. The objective sought in this phase of the Committee's proposed program is to make available to mothers and children of all income groups and in all parts of the United States minimum medical services essential for the reduction of our needlessly high maternal mortality rates an d death rates among newborn infants, and for the prevention in childhood of diseases and conditions leading to serious disabilities in later years.

The Committee recommends a gradually expanding program reaching at least by the tenth year a total additional expenditure of $165,000,000, distributed as follows:

Maternity and care of newborn infants	$95,000,000
Medical care of children	$60,000,000
Services for crippled children	$10,000,000

The Committee recommends that approximately one-half of the cost of the expanded program should be met by the federal government.

Recommendations II, III, and IV: Expansion of Medical Services and Facilities.

The Committee has also explored the adequacy of services for the sick, the sickness experience of and the receipt of professional and hospital services by broad group of the population. The Committee finds that the needs for diagnostic and therapeutic services to individuals are greatly in excess of such accomplishments as might be effected by a strengthened program of preventative services--important as such services may be as a first step. Indeed, it has been recognized in Recommendation I that certain important causes of sickness and death require for their eradication or control, the application of diagnositc and therapeutic procedures through services to individuals in need of such care.

The Committee finds that current practices in the provision of medical services and facilities fall far short of meeting these needs. It has taken account of personnel and facilities, financial support of services required by persons who are themselves unable to pay for the care they need, the sickness burdens of self-supporting persons, methods of paying for medical care and of assuring income for workers who are disabled by sickness. It finds that these need warrent an expansion of medical services and facilities on a broader front than that contemplated by Recommendation I alone.

Recommendation II: Expansion of Hospital Facilities.

The Technical Committee has made a special study of deficiencies in existing hospital and other institutional facilities. It is impressed with the increasing part which hospitals play, year after

year, in the health and sickness services. Without adequate hospitals and clinics, it is impossible to provide many of the important services which modern medicine can furnish.

The Committee finds hospital accommodations and hospital organizations throughout the country ill-adapted to the varying needs of people living under different social, economic and geographical circumstances. In hospitals offering general care, the percentage of beds supported by patients' fees is out of proportion to the ability of the population served to pay; hence many general hospital beds are empty a large part of the time. Conversely, there are too few low-cost or free beds to satisfy the needs. By far the greater majority of these are found in our large metropolitan centers. There are wide areas--some 1,300 counties--having no registered general hospitals, others are served only by one or two small proprietary institutions. Only in large city hospitals have out patient clinics been developed to any considerable extent; governmental tuberculosis sanatoria and mental institutions tend to be overcrowded, or are otherwise restricted in funds or personnel for rendering the community service which they should be equipped to give.

The Committee recommends a ten-year program providing for the expansion of the nation's hospital facilities by the provision of 360,000 beds--in general, tuberculosis, and mental hospitals, in rural and urban areas--and by the construction of 500 health and

diagnostic centers in areas accessible to hospitals. These new hospitals or units would require financial assistance during the first three years of operation. Special federal aid for this purpose is suggested.

Averaged over a ten-year period, the total annual cost of such a program, including special three-year grants for maintenance of new institutions, is estimated at $146,050,000 divided as follows:

	Construction	3-year Maintenance
General and special	$63,000,000	$21,600,000
Tuberculosis	15,000,000	6,000,000
Mental	32,500,000	7,800,000
Diagnostic centers	150,000	
Total average annual cost	$110,650,000	$35,400,000

The Committee recommends that approximately one-half of this total annual cost be met by the federal government. It points out that a hospital construction program should not be undertaken unless there is a concurrent program to give continuing aid toward the cost of free services such as included in Recommendation III.

Recommendation III: Medical Care for the Medically Needy.

The Committee is impressed with the evidence now available that one-third of the population which is in the lower income levels is receiving inadequate general medical services. This applies to persons without income and supported by general relief and to those being supported through old age assistance, aid for dependent children, or work relief, and also to families with small incomes. These people are doubly handicapped. They have higher rates of sickness and disablement than prevail among groups with larger in-

comes, and they have lesser capacities to buy and pay for the services they need. Current provisions to assist these people--though generously given in many state and local governments, by voluntary organizations, and by professional practitioners--are not equal to meet the need.

The Committee recommends that the federal government through grants-in-aid to the states, implement the provision of public medical care to two broad groups of the population: (1) To those for whom local, state or federal governments, jointly or singly, have already accepted some responsibility through the public assistance provisions of the Social Security Act, through the work relief programs or through provision of general relief; (2) To those who though able to obtain food, shelter and clothing from their own resources, are unable to procure necessary medical care. It is estimated that, on the average, $10.00 per person annually would be required to meet the minimum needs of these two groups for essential medical services, hospitalization, and emergency dentistry. This part of the program might be begun with the expenditure of $50,000,000 the first year and gradually expanded until it reaches the estimated level of $400,000,000 which would be needed to provide minimum care to the medically needy groups. The Committee recommends that one-half of the total annual costs be met by the federal government.

Recommendation IV: A General Program of Medical Care.

The Committee directs attention to the economic burdens created

by sickness for self-supporting persons. There is need for measures which will enable people to anticipate and to meet sickness costs on a budget basis.

No conclusion has emerged more regularly from studies on sickness costs than this: The costs of sickness are burdensome, more because they fall unexpectedly and unevenly, than because they are large in the aggregate for the nation, or, on the average, for the individual family. Except in those years when unemployment is widely prevalent, sickness is largely the cause of social and economic insecurity. Without great increase in total national expenditure, the burdens of sickness costs can be greatly reduced through appropriate devices to distribute these costs among groups of people and over periods of time.

The Committee recommends consideration of a comprehensive program designed to increase and improve medical services for the entire population. Such a program would be directed toward closing the gaps in a health program of national scope left in the provisions of Recommendations I and III. To finance the program, two sources of funds could be drawn upon: (a) General taxation or special tax assessments, and (b) specific insurance contributions from the potential beneficiaries of an insurance system. The Committee recommends consideration of both methods, recognizing that they may be used separately or in combination.

Such a program should preserve a high degree of flexibility, in order to allow for individual initiative, and for geographical

variations in economic conditions, medical facilities, and governmental organization. It should provide continuing and increased incentives to the development and maintenance of high standards of professional preparation and professional services; it should apportion costs and timing of payments so as to reduce the burdens of medical costs and to remove the economic barriers which now militate against the receipt of adequate care.

Planning for a program of medical care of a magnitude to serve the entire population essentially must be approached as an objective to be fully attuned only after some years of development. The role of the federal government should be principally that of giving financial and technical aid to the states in their development of sound programs through procedures largely of their own choice.

Recommendation V: Insurance Against Loss of Wages During Sickness.

The Committee recognizes the importance of assuring wage-earners continuity of income through periods of disability. A disability compensation program is not necessarily part of a medical care program, but the cost of compensating for disability would be needlessly high if wage-earners generally did not receive the medical care necessary to return them to work as soon as possible.

Temporary disability insurance can be established along lines analagous to unemployment compensation; permanent disability (invalidity) insurance may be developed through the system of old-age insurance.

Cost of the Proposed Program

The maximum annual cost to federal, state, and local governments of Recommendations I, II, and III (with duplications eliminated) is estimated at about $850,000,000. This figure is the estimated total annual cost at the full level of operation within a ten-year period, and is presented primarily as a gauge of need.

The estimated total includes (1) $705,000,000--though additional annual expenditures for certain general health services to the entire population and for medical services to limited groups of the population--the public assistance and otherwise medically needy groups--which should be reached within a ten-year period, and (2) $145,000,000--the approximate annual cost of hospital construction and special grants-in-aid in the ten-year program proposed under Recommendation II. It is suggested that the federal share of this amount would be one-half.

Recommendation IV is presented primarily as a more economical and effective method of making current expenditures for medical care, though it also makes provision for the medical care of persons who are not now receiving even essential services. An adequate general program of medical care is proposed in the form of alternative arrangements which may cost up to a maximum of $20.00 per person a year, i.e., no more than is already being spent through private purchase of medical care. Annual aid from government funds would be necessary to provide services for the care of the medically needy as proposed in Recommendation III and for the parts of Recom-

mendation I which are included in the broad program set forth in Recommendation IV.

The Committee calls attention to the fact that, in some important respects, the five Recommendations present alternative choices. However, the Committee is of the opinion that Recommendation I and II should be given special emphasis and priority in any consideration of a national health program more limited in scope than that which is outlined in the entire series of recommendations.

The Technical Committee on Medical Care is firm in its conviction that, as progress is made toward the control of various diseases and conditions, as facilities and services commensurate with the high standards of American medical practice are made more generally available, the coming decade, under a national health program, will see a major reduction in needless loss of life and suffering--an increasing prospect of longer years of productive, self-supporting life in our population.

Some New Plans for Medical Care

We have seen in preceding pages that aritculate pressure groups purporting to represent the great masses of people, the National Government Administration, many lay journalists, and, indeed, very many members of the medical profession, firmly believe that the present system of administering medical care is inefficient and inadequate and that some change needs to be made in this system.

In certain localized communities, the need has been great enough, or appreciation of it keen enough, that some changes from the old "fee-for-service" system have been made. The number of different plans for caring for large groups of persons established in these various communities is very large, but they can be reduced to a few basic types, typical examples of which will be presented in this section, so that the reader will have some idea about what sort of social experiments in medical care are going on in the effort to solve the health problem of large groups of similarly situated people.

Some of these plans have been initiated, financed, and managed by physicians, some by laymen, or lay groups, and some by physicians and lay groups working together. A few short years ago, all were frowned upon and even openly fought by organized medicine in the form of local medical societies. However, during the past few years, particularly the last two, such pressure has been brought to bear

upon organized medicine, that it has had to modify its attitude rather markedly. In fact, organized medicine has brought forth several new plans itself, and examples of these will be given in later pages. Hospital insurance is another of the proposed solutions now in active operation, and this plan is of sufficient importance to merit special discussion.

Privately Owned Group Clinics

The Mayo Clinic at Rochester, Minnesota, is probably the most outstanding example of a privately owned group clinic which retains the fee-for-service, sliding scale basis of payment. This clinic has always operated upon such a high scientific and ethical level, that no one has felt justified in criticizing it. Indeed, its reputation has been world-wide for many years, both amongst professional men and amongst the laity. The latter probably have more blind faith in "the Mayos'" being the last word in diagnosis, prognosis, and treatment than have the former.

There is no question that the Mayo Clinic has contributed greatly to the whole field of medical research and discovery, and this has no doubt helped justify its existence and method of operation in the eyes of the professional men. As some writers point out, however, this and similar institutions _could_ exploit both its employed doctors and its customer-patients, degrade the quality of medical care provided, and make little or no contribution to medical science. The fact that a private clinic is exposed to both professional

and lay criticism makes it a little less likely to go wrong than the unscrupulous individual practitioner.

The Lahey Clinic in Boston, the Crile Clinic in Cleveland, the Jackson Clinic in Philadelphia, and other well-known private group clinics are similar to the Mayo Clinic in operation.

Group Prepayment Private Clinics

The much publicized Ross-Loos Clinic in Los Angeles is the largest and probably most successful clinic of this type. It was started in 1929, when the employees of the Department of Water and Power of Los Angeles, approached Drs. Ross and Loos and asked them to provide them with medical service on a contract basis. Other employee groups were later added.

The services provided include house calls, office calls, diagnosis and medical treatment, and also surgical treatment of all kinds, either at the Clinic or in the hospital, with no extra charge for hospitalization. Employed members receive all services and supplies free except certain types of expensive medicines, such as insulin or salvarsan, and eyeglasses, but there is no extra charge for refraction.

Dependents of members receive the professional services but must pay for their own hospitalization, X-Ray films, and medicines, and also fifty cents for each office call and one dollar for each house call and other small charges for special procedures.

The cost of the above benefits is $2.50 per person per month.

During 1934, the average extra charges for care of dependents were sixty-eight cents per family per month, making the total cost $3.18 per month for complete medical care to a family. This plan does not include dental service.

At this Clinic, each body of employed persons (only groups are enrolled) has a separate contract with the Ross-Loss Medical Group, and the groups deal with the Clinic through their own health committee which negotiates the contract and makes the payments.

Alden B. Mills and Cameron St. C. Guild, in publication number 13 of the Committee on the Costs of Medical Care, compared the cost and care received by representative families of the same income level and social position in the same locality with that received by a patient of the Ross-Loss Medical Group, and found that for slightly less cost the latter received four times as many office calls, two-thirds as many home calls, twice as many eye refractions, and a larger number of prenatal and postnatal visits per maternity patient than did the former. The non-member families compared also received some of their service without charge or at reduced fees, especially hospitalization, because of their low income level---($1200 to $2000).

The Ross-Loss Group is highly praised by all its members, its members' employers, many prominent physicians, and lay journalists. It was, at first, violently opposed by the Los Angeles County Medical Society, which went so far as to expell Drs. Ross and Loss from membership. However, the Judicial Council of the American Medical Association anticipated that a big verbal battle and a lot of un-

favorable publicity was likely to ensue and so finally reversed the expulsion voted by the Los Angeles County Medical Society.

As for the salaried doctors on the staff of the Clinic, nearly all feel that they are benefitted by their stability of income and freedom from financial worries and, further, feel that they give better service than they would be able to do in individual private practice.

Medical Groups Serving Labor Groups or Unions

The Union Health Center, in New York City, is one of the oldest medical service groups in which members of a union are served by a group of physicians. Since May, 1934, the International Lady Garment Workers Union has had full responsibility for its finances. Some local unions pay the Center for medical care extended to its members, and in other cases individual union members pay fees of $1.00 for examinations and treatments, with much reduced rates on all procedures such as X-Rays and laboratory tests. The medical staff at the clinic is on a salary basis, and outlying district physicians are paid by the visit.

Industrial Medical Services

These include the various plans in operation; for example, in the mining, lumber, and railroad industries wherein employed persons receive more or less complete medical care on a fixed, periodic payment basis. In some of these plans, costs are met entirely

by the employer, in some by the employee; but in most, both share the cost. The method of giving the medical service also varies somewhat. In some cases, a hospital and its out-patient clinic is owned by a non-profit insurance agency; with physicians employed on a salary, and in other cases the insurance group contracts for services with local institutions and physicians at so much per patient or so much per visit.

Medical Cooperatives

One of the earlier successful medical cooperatives in the country was the Farmers Union Cooperative Hospital at Elk City, Oklahoma. This was organized in 1930 by Dr. Michael Shadid with the help of John A. Simpson, then President of the Farmers Union of Oklahoma. The Farmers Union had already built up a strong cooperative movement in this rural community, so its support was not only welcome but necessary.

Dr. Shadid was violently opposed in his plan by the Oklahoma State Medical Society, which ousted him from membership without charges or trial, and even tried to have his license revoked in 1936. This act stirred up a flood of violent criticism of the Medical Society and tremendous sympathy and support for Dr. Shadid, for the Farmers Union is a formidable political force in Oklahoma. The press was also entirely on the side of Dr. Shadid. Later, Dr. Shadid said that one of his major mistakes was in "defying the entire medical profession instead of urging one of two local physicians to join me."

The Farmers Union Cooperative hospital is a cooperatively owned and managed hospital and group clinic, which provides its members and their dependents with complete medical and dental services on a flat monthly or annual fee basis, with minor supplementary charges based on the service received. The persons who join become stockholders in a non-profit cooperative association. The shares cost $50.00 each, payable $20.00 down and $15.00 each succeeding November, and each family must own one share. The resources from shares are used only to pay for hospital land, buildings, and equipment. Stockholders must pay their shares in full when hospitaliaation is received.

A stockholder without dependents pays for his services $12.00 per year, $18.00 if he has one dependent, or $25.00 for a larger family of any size. Payments must be made quarterly in advance. In case of hospitalization, the member pays $1.00 for the first day and $2.00 per day thereafter, with an additional charge for anesthetics and operating room. Private duty nursing is provided for three days without extra charge. Dental examinations, dental X-Rays, and extraction are provided free. Extra charges to stockholders are made as follows: Home calls, $1.50 plus 25¢ per mile one way; X-Ray films (other than dental,) $3.00 for one, $2.00 for each additional. These costs seem quite high, $75.00 the first year and $25.00 a year thereafter--not for complete medical care, but only for about a 50 per cent reduction from the usual costs. A family would need an income of at least $2000 per year in order

to belong to this cooperative, and then the average family would probably not save a great deal thereby in the long run.

The medical and dental staff receive $12.00 out of each $25.00 subscription. All fees are assessed and collected by the business office. There were 2400 members in 1936, contributing a total of $28,800 to be divided amongst the three medical and two dental men who get one month a year off on full pay. As Dr. Shadid says, "The Cooperative is a benefit to both the patients and the staff because the latter fully control the professional end of the work and have as much to say about their compensation as they would in private practice, their pay is steady and averages as high or higher than that of men in private practice, they are free from economic matters such as bookkeeping, overhead, etc., the doctors cooperate fully without thought of jealousy or personal advantages, and the patients come in early and have more confidence in the doctors, for they know that their medical advice is not tinged with personal interest."

Group Health Association, Inc. of the District of Columbia

This particular Association, although also cooperative in type, merits special mention because its activities were used as a basis for a test case between organized medicine and the most influential group in favor of socialized medicine; namely, the present national government administration. On July 31, 1938, close on the heels of the National Health Conference, Assistant Attorney-General Thurman Arnold broke the news that a federal grand jury was about to open

hearings on alleged violations of the anti-trust statutes by the American Medical Association, and the District of Columbia Medical Society. In December, 1938, this jury voted an indictment not only of the District Medical Society and the American Medical Association, but also of the Washington Academy of Surgery, the Harris County Medical Society of Houston, Texas, and twenty-one physicians of Chicago and Washington, including Dr. Fishbein. This was apparently all brought about by the activities of the American Medical Association and District Medical Society in opposing the Group Health Association. The indictment charged that a boycott was instituted against the Association and its medical staff, that hospitals were closed to this cooperative's staff, that physicians of this staff were expelled from the local medical societies, that specialists were forbidden to consult with the Cooperative's physicians, and that "white lists" of approved medical institutions were published on which the Cooperatives name did not appear.

According to laymen sympathetic with this Cooperative, organized medicine did not like the Group Health Association and what it represented because (1) it put some power to determine prices and methods of payment for medical service in the hands of organized purchasers, (2) the organization of physicians into a group, with the resulting gain in efficiency and economy, and the application of the insurance principle of payment, put this patient-controlled cooperative in a position to compete with a lot of physicians out of individualistic fee-for-service practice and into the staff of

the Group Health Association or other medical Cooperative's staff, and, (3) it had an ideal potential membership of 115,912 government employees and their families in and around Washington, whose employment was secure and whose capacity for cooperative organization was relatively high.

Group Health Association was really the brain-child of R. R. Zimmerman, Personnel Director of the Federal Home Loan Bank, and John H. Fahey, Chairman of the Board of the F.H.L.B. and former President of the United States Chamber of Commerce, who decided that the loss of half a million dollars a year through sickness of their employees, must be reduced. At first, the Association offered complete medical care and hospitalization to husband, wife, and children under eighteen for $3.30 a month. This was later stepped up to $5.00, plus a membership fee of $5.00 and an application fee of $5.00. The salary scale of the physicians employed ranged from $2100 to $7200, with a planned later increase to $2400 to $8400.

As part of their attempt to eliminate the Association, the local medical society evolved the Mutual Medical Service Plan, controlled by a board of directors, a majority of the members of which were Medical Society members. Membership in this Service was limited to the low-income group, just above the level of medical indigency. A system of stepped-down fees was used with a limit of $450.00 benefit to any one family per year.

Government Plans in Operation

The Farm Security Administration is the government agency which is trying to rehabilitate a large number of low-income and destitute farm families. In connection with this program, the F.S.A. has organized voluntary health insurance arrangements between local country doctors and these farmers. What the F.S.A. does is to grant loans, $20.00 to $30.00, which is earmarked for medical care and placed in the hands of a trustee, pooled in a common fund, or earmarked individually by families. The family chooses its own physician and he is paid each month in full, or on a prorated basis if that month's bills exceed the amount of money in the pool. This is obviously not a very satisfactory plan for any of the parties concerned, but is certainly better than letting the physicians do as much entirely free work as they have been doing. Probably few of the recipients of the loans would have laid by any money out of their loans for future medical needs on their own initiative.

The Federal Emergency Relief Administration also had a plan for partial medical care of the indigents it served. In general, it provided for acute illness, conditions which interfered seriously with earning capacity, and for conditions which endangered life or threatened a new handicap preventable through medical care. It also set aside $1.00 per month per family for payments to the doctors-- this at the rate of $1.00 per office visit and $2.00 per home call.

These plans, of course, were entirely inadequate and made no

pretense of supplying the needed care. F.E.R.A. officials themselves estimated that "four or five times the amount of present expenditures is needed."

Plans Under Professional Sponsorship

Care of indigents by the local County Medical Society through contract with the local government is a plan which has been tried in many counties of many states. The funds are customarily used to pay the physicians' dues to local, state, and national medical associations, and the residue, if any, is pro-rated to the physicians on the basis of their work. The "officially indigent" may go to any doctor they choose. This often results in an excessive burden on a few physicians, as there is never enough money to pay the physicians anything like what their service is worth. Also, preventive work is not done sufficiently, and there is usually no provision in the plan for dentistry, nursing, or hospitalization.

Provision by county medical societies of insurance for high-cost illnesses is a plan which originated in Wisconsin in 1932. Under this plan, individuals and groups pay monthly dues (based on incomes) in return for designated professional services which may be rendered by any of the participating physicians. The net result of the financial arrangements is to protect the subscriber and his family against the burden of catastrophic illnesses only. Simple illnesses continue to be paid for on a private fee basis up to a certain total amount (fixed according to income) in any one

year under this plan.

Joint use of professional personnel and equipment, including office space, nurses, X-Ray equipment, laboratories, etc., needs only be mentioned here as a plan extensively used.

A complete discussion of the various plans being experimented with by the medical societies is given in another section of the paper.

Plans Under Consumer Sponsorship

Medical service under Workmen's Compensation laws is now in effect throughout the nation. Medical service is paid for accor ding to a fixed fee-schedule. Employers insure their liability through a commercial company, may self-insure, or may insure in the state fund. In many states a maximum liability is specified; in others it is not.

Medical service furnished by employers is a plan which has been in effect for a long time in some industries. Formerly, the medical service provided was largely a low-grade type, but in recent years there has been a substantial growth in both quality and amount of service provided. The Endicott-Johnson Corporation, for example, provides its employees with the services of general practitioners and specialists, hospitalization, dentistry, nursing, and laboratory and X-Ray service. This service costs the company a bout $22.00 per year per individual to whom it is potentially available.

Medical service provided by employee groups is, of course, not a new plan. There are several hundred employees' mutual benefit

associations which provide various kinds of cash and other benefits to their members. One such organization in Louisiana furnishes complete medical, hospital, and nursing service to its members at a cost of $3.00 per employee per month.

Medical service provided jointly by employers and employees is another plan rather widely used. In one such plan in North Carolina, the employees pay twenty-five cents per week apiece, and the employer pays about twice that amount. The employees receive unlimited medical, hospital, and nursing care.

Plans Under Community Sponsorship with Professional Participation

Middle-rate hospital services is a plan illustrated, for example, by the Baker Memorial unit of the Massachusetts General Hospital, in which there is an agreement between the medical staff and the hospital on a fixed maximum schedule of charges for professional as well as for hospital services, and the hospital administration adjusts and collects all charges.

Pay clinics are an outgrowth of the out-patient departments of many hospitals, which formerly served only the indigent but now serve, in many localities, those persons who are not indigent, but who cannot meet the usual expense for private medical care. Physicians are on a salary or fee basis, and the patient pays the full cost of the services, but the cost is lessened because no capital charges are included and there are many economies of organization

and limitations on the returns to the practitioners. Some pay clinics, like the Cornell Clinic in New York City, provide general services; others are limited to special fields.

Government health services have been increasing by leaps and bounds during the past few years. In some cases private physicians are utilized to make immunizations and diagnosis as a follow-up to a health department survey, and in other cases, the health departments have taken over work formerly done by private practitioners. The health departments are usually careful to try not to step on the toes of the private physicians.

Government provision of hospitalization by local governments has been tried in some large communities, such as Cincinnati and Buffalo. The hospitals are open to all residents (with a few restrictions) at relatively low rates, and thus assist patients in meeting the costs of hospitalized illnesses, which constitute about 50 per cent of the total cost of all medical services.

Tax-supported physicians in rural areas of Saskatchewan have been practicing since 1921 on a full-time salary basis. The cost of their services figures out about $8.00 to $10.00 per family per year, but, of course, this does not include hospitalization, nursing, dentistry, specialists, or other "refinements." The physicians seem to be satisfied, and no community which has ever started the plan has given it up.

Plans Under Commercial Sponsorship

Installment payments through loan companies have been used quite extensively by patients in the paying of medical bills. It is estimated that about 28 per cent of all such personal installment loans are made for this purpose. The trouble is that the loan companies are too often managed by unscrupulous persons, who charge from 12 to 200 per cent interest, and the interest rates only increase the total burden and prolong the misery of the patient.

Health insurance "as provided by commercial insurance companies" is fully discussed in another section.

Medical benefit corporations operating for profit have existed for some time, particularly in California. These are organized by laymen and sell health insurance for profit, service being provided through contracts with private practitioners and hospitals. They have been entirely unsatisfactory, because many have been started with insufficient capital and have failed, and further, much of the medical service has been purchased from the lowest bidder and consequently has been of poor grade.

Hospital Insurance

Insurance against the costs of hospital care originated as a "hospital service plan" (non-profit organisations) in 1932, was formally approved by the National Hospital Association in 1933, and is now claimed to cover some five million persons. It is perhaps significant that at least 65 per cent of these persons live in four areas; namely, New York City, Cleveland, Rochester, N.Y., and Minnesota.

The hospital service "plans" often called group hospitalization--utilize the principle of insurance to remove the uncertainty of the costs of necessary hospitalization from a group of individuals who make equal and regular payments into a common fund, which is used for the payment of their hospital bills.

One fundamental theme of these organizations is that they are "non-profit", and many of their managers and advocates dislike them to be called "insurance companies." In contrast to strictly commercial health insurance companies, (which are discussed in another section of this paper), they offer simply a service contract. They possess the facilities to render the service and simply apply the law of averages in figuring pre-payment costs. Only hospitals can guarantee hospital service.

According to proponents of this plan, it protects the people by giving them organizations of their own choosing, no tax burden is added by government donations, the extensive bureaucracy of

of government plans is eliminated, politics plays no part, and by relieving patients of their hospital charges, they make them better able to pay the physician for his service.

It is no doubt true that insurance against the cost of physicians' services will develop in combination with hospital care insurance, for the public will not bother to pay two separate bills for such closely related services, and the fact that hospitalized illnesses account for at least one-half of our annual bill for all medical services, the hospital bill itself being 50 per cent of the cost of hospitalized illness, makes this relationship even more natural. However, it seems obvious from the foregoing figures, that since the hospital bill is probably a little less than 25 per cent of the total bill for medical care, hospital care insurance, at its best, can solve only part of the problem. Further, it is estimated that only 7 per cent of the population is hospitalized in a given year, which means that 7 per cent of the people would receive 25 per cent of the benefits, while contributing only 7 per cent of the cost under a comprehensive hospital insurance plan, but that is the way of all insurance schemes.

Hospital care has never been considered a private commodity, to be withheld from persons unable to pay. More than 70 per cent of the million hospital beds in American are in government hospitals, and 25 per cent more are in non-profit hospitals, built through charitable contributions. In any one year about 30 per cent of the patients hospitalized for acute illnesses receive care free of cost

to themselves, and another 20 per cent pay less than the regular charges for hospital care. The ratios of free service are higher in the larger cities. Almost any person who is unable to pay can get needed hospitalization..Persons with sharply limited incomes do not like to be placed in the same category with "free" patients, and it is especially to these people that hospital insurance appeals and for whom it is particularly intended. Hospital administrators and trustees, too, like the insurance plan, because it helps regularize hospital income.

As Dr. Graham L. Davis points out, it is the unanticipated burden falling upon the individual with limited income which constitutes one of the most important problems in medical economics. Sudden appendicitis or an auto accident with charges of $200 to $300 frequently means financial tragedy or charity or both to a large part of the population. He estimates that two out of five patients in a general hospital do not pay their hospital bill. The only solution appears to be to get a substantial part of this unpaid amount from the patients by the spreading of the cost over large groups of people and long periods of time on the insurance principle. But, the majority of persons now enrolled in the group plans could and would pay their hospital bills without group hospitalization insurance, and nothing has been done to solve the problem of the 60 to 70 per cent of people who do not now pay the full cost of hospital care which they need and should have, according to Dr. Davis. His solution is a payroll deduction for industrial workers

and a stamp plan for rural areas, such as is used by the Merseyside Hospital Council in Liverpool, in which a person carrys a card upon which he must place a stamp each week and he gets hospitalization only if his card is stamped up to date. The payroll deduction is also used in Liverpool, where it is known as the "penny in the pound" system. There each worker pays a penny for each pound of his earnings, and the employer adds a third to the total and keeps the books.

Generally speaking, the hospital service groups feel that if governmental authorities will provide care for the generally indigent, hospitals and organized medicine will take care of those who are able to pay moderate fees. They recommend a voluntary health insurance program, controlled largely by the doctors, which will be on a pre-payment plan, non-profit, limited to restricted income groups, and with free choice of hospital and doctor. They are certain that "if the medical profession and the hospitals are not alert they will be given by Capital and Government to Labor as a political peace offering", and that "if the insurance principle is not soon applied to this problem on a voluntary basis, it will have to be done on a compulsory basis, and when that has happened in other nations, the government has taken over the hospitals and the next step has been for the government to take over the medical profession."

The Associated Hospital Service of Baltimore is a rather typical example of a hospital insurance organization as above described.

Under this plan the "subscribers" pay into a "fund" out of which the hospitals are paid a per diem. The participating hospitals agree to provide subscribers with complete hospital service for twenty-one days in a given year, without additional cost to the subscriber. The top limit is $5.00 per day for a room. If a patient wishes a more expensive private room, he is allowed $5.00 a day credit on his room and a 50 per cent discount on all "extras." Full X-Ray service is included. Obstetrical care is not included in the Baltimore plan, "because it is expensive to the membership as a whole, since a small percent of the total get any benefit, yet the additional cost is at least $1.37 per year for every subscriber." Further, this plan is largely intended to cover hospitalization for which there has been no warning, and this is not true in obstetrics. The cost of this insurance plan is seventy-five cents per month to the subscriber, $1.50 for husband and wife, or $2.00 per month for the whole family (including only children between the ages of three months and nineteen years), and they are allowed twenty-one days of hospital care apiece per year.

Another typical and slightly different hospital insurance plan is in operation in Omaha, Nebraska. Known as the "Community Hospital Care Plan," this organization offers a plan of hospitalization insurance with the following provisions:

1. Twenty-one days of hospital service for the subscriber the first year; twenty-four days the second year; twenty-seven days

the third year; thirty days the fourth year.

2. Board and room in a two to four-bed room in any member hospital, or $3.50 per day allowance toward the cost of private room; or $5.00 per day allowance for the subscriber for hospitalization in any other licensed hospital in the United States or Canada.

3. Operating Room as often as needed in any hospitalization period.

4. Anesthesia as often as needed in any hospitalization period when administered by a salaried employee of the hospital.

5. Drugs and medicines up to $10.00 in each period.

6. Surgical dressings up to $10.00 in each period.

7. Laboratory service is confined to routine blood count and urinalysis in each period.

8. Allowance of $10.00 for oxygen therapy, inhalations, and sera in each period.

9. Maternity service with nursery care and use of delivery room after ten months membership.

10. For hospital services rendered after period to which the subscriber is entitled a 25 per cent discount is allowed for an additional period not to exceed sixty days.

11. No allowance is made for X-Ray, metabolism tests, electrocardiograms, fever therapy, diathermy, radium, or tissue examination.

12. Hospital service is not provided for rest cures; mental, tuberculosis, venereal, or alcoholic cases; drug addiction; Workmen's Compensation cases; or, for any of the quarrantinable diseases.

13. Subscribers are taken only from employed groups, and at least 40 per cent of each group must subscribe. Payments are made to the central office through payroll deduction, or through a secretary for each group.

14. Dependents may also be insured on the same contract, and one-half benefits are allowed for them.

15. The cost is seventy-five cents per month for the subscriber, $1.00 for subscriber and one dependent, or $1.25 for the entire family. Dependents include wife or husband and children, three months to eighteen years of age.

At the end of its first year of operation in Omaha, this plan had enrolled 5527 members; 465 members of this group had been hospitalized for a total of 2828 days at a cost to the organization of approximately $14,000. This is an average of six days hospitalization at a cost of a little less than $5.00 per day for each member requiring the service. So far, the Omaha plan has been very successful.

In most plans, benefits are available for all types of illness or injury exclusive of those covered by Workmen's Compensation laws. Usually excluded also are services for the care of nervous, mental, and tuberculosis cases "as such". The same rule applies to contagious diseases not ordinarily accepted by the member hospitals. Some of the early contracts did not cover venereal disease, self-inflicted injuries, diseases not common to both sexes, and injuries sustained during riots, war, or violation of the law, but experience has indicated that they are negligible in incidence (relative to total

causes for hospitalization), and most plans now limit their restrictions solely to nervous and mental, tuberculous, and contagious conditions. Even the latter group apparently are not important factors in the total cost to the subscriber of the plan, and there is a tendency to include these conditions for the regular maximum period of hospitalization, because of the public health values resulting from such care. Maternity care is provided in nearly all plans, only after a suitable waiting period, usually a year. There is in most plans a maximum number of days of hospital care to which a subscriber is entitled, and this number is twenty-one in the majority of plans, as high as thirty in a few.

Further provisions in nearly all hospital service contracts are for use of operating and delivery room, drugs, dressings, and laboratory services, in most cases with a maximum limit on these features. A few of the plans provide for limited physiotherapy services and about half for radiological services and anesthesia service.

The American Hospital Association has given special attention to the problem of medical practice in hospitals. The Association says that more than 10,000 physicians are employed by hospitals on a full or part-time basis for the care of the sick or for laboratory services. Such financial relationships are particularly common in the laboratory and X-Ray departments from which diagnostic services in hospitals is part of the responsibility of the hospital

and is consistent with the rights, privileges, and obligations of the hospital staff physicians under their medical licensure. The performance of diagnostic and therapeutic procedures by staff members constitutes the practice of medicine _in_ hospitals, but it is not the practice of medicine _by_ hospitals, according to the Association.

Non-profit hospital service plans are concerned primarily with "group" enrollment procedures, for this is one of the chief ways by which costs of promotion and collection are kept at a minimum. The enrollment of "individuals" not only runs up the costs, but individuals in need of hospitalization tend to seek insurance protection for their illnesses. Subscriber payments are made through payroll deduction or through a remitting agent who is elected from amongst each group of employees insured.

So far, there has been practically no enrollment of rural populations in hospital service plans. This is because rural residents have not in the past demanded or received the same amount of hospital care as urban dwellers, because the scattered population is not conveniently grouped for purposes of enrollment or collection, and because the executives of the plans have been "too busy" in the urban communities to give much attention to village dwellers and farmers.

One method suggested to service the farmers is to use their various organizations (bureaus, granges, unions, cooperatives) as agents for obtaining applications and collecting subscriptions. Another method suggested is to regard each farm family as part of the town or village, and to permit farmers to apply for membership

through some agency in the community, such as a bank or newspaper office.

The economic basis of subscription rates is the fact that experience has shown there to be an average of from .7 to .85 hospital days per person per year over the entire population. Subscription rates are therefore set high enough in each community plan to provide each eligible subscriber with an average of one day's care per member year (or three days per family year), plus a reasonable allowance for field service, administration, and contingencies. If a hospital service plan proposes to pay member hospitals an average amount of $5.00 per day for each day of care provided, and an allowance is estimated at $2.50 for the average annual expense involved in the administration of each contract, and an enrollment fee of $1.00 is charged, then hospital insurance could be supplied for a minimum of $8.50 per member per year. Actually, by far the most common subscription rate charged is seventy-five cents per month, or $9.00 per year per subscriber, or $18.00 for husband and wife, and $24.00 for a family contract.

Commercial Health Insurance

We have seen in preceding pages something of what the needs are today as regards medical care. Figures have been given on the distribution and costs of medical care. Many plans for administering and distributing medical care, and their cost to the consumer (patient) have been discussed. In foregoing paragraphs, much has been written about various insurance schemes, some actually in operation now, and some proposed.

Open opposition to any insurance scheme has been the policy of organized medicine and certain other groups until very recently. Advocates of the insurance principle in medical care started with a plan for simply group prepayment practices within the various separate industries, went on to urge voluntary insurance for everyone, and now demand compulsory health insurance for all people with incomes under $2000 of $3000 per annum.

The former opposition has been partially converted. Organized medicine now urges further experimentation in group practice clinics. Many outstanding physicians and many leaders in organized medicine now recognize the value of voluntary health insurance and urge that it be more widely used. It seems therefore pertinent to find out at this time just what needs voluntary health insurance plans satisfy, whether or not they offer what the consumers (patients) want, and whether it would be possible for them to be extended for even greater coverage than now exists.

Voluntary health insurance can be purchased only from commercial insurance organizations, or rather, only commercial insurance organizations sell health insurance, for it must be sold even today. Very few persons seek to buy it without considerable solicitation. The many "group health insurance" plans, wherein whole groups of employees of a firm are insured, are also underwritten by commercial insurance companies, and a typical example of such a group plan will be discussed later.

For the purposes of this paper, a study was made of various types of insurance coverage offered by the largest health and accident association in the world. This company writes nearly five-hundred different kinds of policies, so the examples given here are no doubt representative of the types of coverage offered by nearly all companies and will suffice to illustrate what is available to various groups of people in the way of voluntary health insurance.

Although the particular company studied writes nearly five-hundred different kinds of policies, they may be classified into five main types. These are: (1) An "A" type for business and professional men--a selected group; (2) a general worker's type of policy for employed persons in the common occupations; (3) a medical attendance and hospitalization type of policy; (4) a group of policies each of which is designed for a different particular group of persons in the various "hazardous" occupations, such as mining, lumbering, and etc., each of these containing different special clauses and benefits pertaining directly to the particular class of

of persons insured; and, (5) a group of "special" policies for specific accidents such as being struck by a golf ball, killed or injured by an automobile, drowned, killed in an airplane accident, and so on ad infinitum. The different policies within each of these main types differ almost entirely only in the amount of benefits paid and, proportionately, in the premiums charged in each case.

Some of the standard provisions found in all policies offered are worthy of special mention.

No benefit is paid to the insured in any case for illness or for loss of time unless he is continuously under the professional care and regular attendance, at least once a week, beginning with the first treatment, of a licensed physician or surgeon, other than himself. This clause is perhaps desirable in that it encourages the insured to seek medical advice and attendance early, and thus make possible early diagnosis and treatment and so lower total length of disability, and decrease morbidity and also lower general mortality by early care of conditions which might prove fatal if not caught early in their morbid processes. There is possibly a slight shortcoming in this clause in that there are many times, theoretically at least, and particularly from the insured's viewpoint, when an illness is disabling in that he does not feel like going to work, yet it is not severe enough that it warrants calling a physician. The common "upper respiratory infection" affects many persons this way, and several such infections a year would mean quite a little pay lost and seriously affect the budget of a small wage-earner.

Of course, from the physician's viewpoint and from an epidemiological viewpoint, any person sick enough to stay home from his work should be seen at least once by a physician. This would help avoid possible complications or mistake of a minor illness for a serious illness, and also make it possible for the insured to receive his benefits. Some policies cover part of this problem by not allowing any benefits until the insured has been disabled at least three days.

Another standard provision provides that "this policy does not cover death, disability, or other loss while the insured is suffering from syphilis or venereal disease; or while suffering from insanity or mental infirmity." If this clause were interpreted literally, a person who contracted syphilis, for instance, three months after taking out a policy and then a week or two later accidentally had a limb severed in an automobile or train wreck, could not recover his benefits under the policy. Actually, of course, a test for syphilis would almost never be run in such a case, and the insurance company would go ahead and pay the claim. But, a person with syphilis might get appendicitis, or have an intestinal obstruction or other unrelated illness, and need medical attendance and hospitalization. In such a case, it is extremely doubtful if the insurance company would pay the benefit for such an illness, if it were discovered that the policyholder (patient) had syphilis. This, of course, does not seem right and there should be some latitude in interpreting this clause. The reasons the insurance companies will not pay benefits on venereal disease are

because of the long course of treatments required for cure, because of the relatively high incidence of such disease, and because they feel that it is an act of negligence on the part of the insured if he acquires such a disease. They are apparently willing to gamble only on the unpredictable accidents and diseases over which the insured has no control. As for mental infirmities, it is obvious that a commercial organization can not gamble on persons with psychoses or frank feeblemindedness. However, there are a great number of minor psychoses or neuroses which need expert medical attention and advice and even hospitalization for a short time, and, if we can believe the psychiatrists, a great deal can be done to rehabilitate and put back to work persons with this type of illness. Just why diseases of the stomach, for example, are insurable, while diseases of the mind are not, is not quite clear. Perhaps it is because of the prevailing lay impression that when anything goes wrong with the mind or personality--nothing can be done about it. Psychiatrists and well-informed medical men certainly differ with this viewpoint. It is true that almost all well-informed persons are in favor of government care of institutional mental cases, but some provision needs to be made for the large group of minor psychotics, who are walking around without jobs or doing inferior work at the job they have. Under all plans presented so far, the psychiatrists are apparently going to work only in the mental institutions.

Further, according to all policies examined, "disability resulting from tuberculosis or heart trouble shall be covered only if

the disease originates after the policy has been in continuous force for the six preceding months." It is now accepted by most physicians that a healthy adult may develop tuberculosis which will terminate fatally in less than six months. Certainly it takes less than a year and usually less than six months for a case to develop from a subclinical to a very active and disabling process. Why, then, must the insured wait six months before he can collect disability? Or, if the clause be interpreted literally, he could often not collect at all because the disease must "originate after the policy has been in continuous force for the six preceding months." The same general remarks can be made about heart disease. A person may be entirely unaware of any heart ailment and decompensate to a completely disabling state over a period of a few weeks or even less. Yet, if he had not bought his insurance more than six months before, he would not receive any benefits at all. These people have to be taken care of some way, and commercial health insurance policies certainly do not cover many of them. Of course, insurance companies must protect themselves. They cannot get on the risk of persons who have active tuberculosis or persons who have any evidence of heart disease. As these two conditions are usually chronic in nature, the insurance underwriters have found, that if disability does not develop within the first six months, they can afford to carry the risk. If they were to insure everyone indiscriminately, benefits paid out would beso great that rates would have to be prohibitively high to keep the company solvent. It is also common

opinion that the care of tuberculosis should be the responsibility of the state. This is no doubt true of late or advanced cases, which require a long period of hospitalization, but a newer concept of ambulatory treatment makes the old theories at least partially untenable. For example; a young individual whose case is diagnosed early and who has no pleural adhesions, may be treated with pneumothorax on an ambulatory basis and continue with part or all of his work, if it is light work and if he is under careful and frequent medical supervision. Under present commercial policy forms, he cannot be reimbursed for his doctor bill or for partial loss of time. Some provision is necessary for this type of case. The same thing is true of many other illnesses, including many cases of heart disease, which require more or less medical care, yet which may cause no loss of time or only partial loss of time. These persons are, in many cases, barely able to be self-supporting when they have no bills for medical care and when it becomes necessary for them to visit or be visited by a physician several times, the resulting bills put them in the classification of the "medically indigent." In the past, and at present, the physician has simply donated his services so that the patient can remain economically independent. This is not sound economics. Commercial health insurance does not at present provide for such cases, so unquestionably some plan must be worked out to provide for situations like this where the disability is not "total."

Still another standard provision found in nearly all policies

provides that no benefits are payable for bodily injury or sickness caused by alcoholism or self-inflicted injuries. This clause is, of course, necessary as no one is entitled to benefits for such conditions for obvious reasons.

Many policies also do not cover any injury sustained by practicing for, or participating in, certain sports, such as football or basketball. This, like the other standard restricting clauses, is inserted in policy forms as the result of many years experience. By eliminating benefits for such injuries and illnesses, the commercial insurance carriers are able to keep down somewhat the costs of the coverage to the insured persons. If they want all such conditions and situations covered, they must pay extra for them.

All policies also contain a clause which states that "if the Insured shall carry with another company, corporation, association, or society other insurance covering the same loss without giving written notice to this company, then in that case this company shall be liable only for such portion of the indemnity promised as the said indemnity bears to the total amount of like indemnity in all policies covering such loss, and for the return of such part of the premium paid as shall exceed pro rata for the indemnity thus determined." At first glance, this clause seems unfair to the insured, for he is entitled to all the benefits for which he is paying, and he pays full price for all benefits received in each and every policy. It seems that he should be able to carry, for example, $50.00 a month disability benefit in one company and $50.00 in another company. This

would be good business for the insured in that it would leave him with some protection in case one company became insolvent, or call it "diversification of investments" or "not putting all your eggs in one basket," if you will. This clause, too, is the result of many years of bitter experience. It keeps the insured from loading up with accident and health insurance beyond his economic value, then making a nice profit off of any accident or illness, or even faking an accident or illness, and making it stick with a sympathetic jury who allow full claims--juries have been notorious for rendering decisions adverse to large "soulless" corporations. They say, "Oh well, he is a poor man, and a big corporation like that can afford to pay it."

Special clauses will be discussed under the various types of policies in which they are found.

Business and Professional Men's Policy

This policy was selected from the group of "A-series" policies as an example of the type of insurance coverage available to business and professional men--a select group whose hazards are relatively less; hence, they get somewhat more protection for the same cost than do, for example, common laborers.

The first part of the policy provides for specific accident benefits such as loss of hand, foot, eye, or life, and for total disability benefit in case no specific loss of body parts occurs. In the first case, a definite lump sum is paid for the specific

loss, and in the second case, a definite amount per month is paid to the insured so long as he is totally disabled.

The second part of the policy provides for the payment of a definite benefit per month to the insured in case of total disability due to sickness. The benefit is continuous in case the illness is confining, but is limited to three months if the illness is non-confining. An additional benefit is paid if the illness or accident requires hospitalization.

The cost of this policy is $80.00 per year for potential benefits of $200 per month, proportionately less if benefits are reduced. It is estimated that a person whose monthly income is about equal to the total maximum benefit per month can afford to buy this policy.

This type of policy is intended to insure against loss of time rather than to provide specifically for medical care. It is no doubt true, as many argue, that freedom from worry about lost wages contribute greatly to speed of recovery from illness and injuries. It is proper and feasible for a single commercial insurance policy to provide for both loss of time and cost of medical care. In the new plans for medical care, many of which have been discussed in preceding pages, there is not a proper correlation between cost of medical care per se, and compensation for lost time. In fact, one of the big criticisms by physicians of the new plans is the too-close tying up of compensation with payment for medical care. As has been pointed out before, physicians can not and should not have the major responsibility for the compensation element. That must be kept separate

from the medical care element. With the commercial insurance plan as herein described, it is bad enough for the physician to have to fill out the numerous blanks which he now does, usually without remuneration, without adding any more burdens of bookkeeping.

An important point to remember is that commercial insurance companies do not offer any service, medical or hospital. They simply offer a guarantee of cash remuneration, on an insurance-risk basis, to the insured for any loss of body parts and time which he may incurr at any future time.

General Worker's Policy

The policies of this group are sold to any employed person regardless of sex or occupation. In general, they provide indemnity for loss due to hospital confinement and other specific losses necessitated by bodily injury or sickness.

A policy of this type provides an allowance of a certain amount per day for hospitalization, an allowance for the surgeon's fee (according to a limited schedule), for special nursing care, and for visits by the doctor at a rate of so much per visit.

If benefits for dependents are also desired under this policy, half benefits under section A (to pay the hospital) and under B (to pay the surgeon) are provided at half the regular rate.

This policy contains all the standard provisions mentioned previously and in addition, states that it does not cover maternity cases or complications arising therefrom unless the policy has been in force

for ten months or more, and then to an amount no greater than ten times one day's hospital benefit. This would cover the average home delivery, but would not be sufficient to pay for a hospital delivery and the obstetrician's bill.

This policy also does not cover hernia, unless the hernia originates six months or more after the policy has been in effect, an d then to an amount not greater than ten times one day's hospital benefit, again an entirely inadequate sum. The insurance companies have found that it is necessary to protect themselves in this way, for if they did not, a worker would simply wait until he acquired a hernia, a very common industrial disability, then take out insurance, have the hernia repaired, then drop the insurance. This would soon throw the insurance company into insolvency.

These deficiencies can hardly be avoided in any individual insurance plan. The only way an insurance company can offer complete protection is to insure a very large block of persons with a definite agreement that they will keep paying on the insurance for a long period of time.

The total cost of the policy just described is $2.40 a month, or $28.80 per year, a figure as high as most estimates of the cost of complete medical care under any of the new plans suggested, and it offers considerably less protection. There is probably adequate coverage for possible surgeon's fees, inadequate coverage for nursing care, and very inadequate coverage of possible and even probable doctor bills. If a man had four dependents to be insured, the additional cost under this policy would be $5.20 per month, or $62.40 per year

for only hospital and surgeon's fees protection. This makes a total of $91.20 per year net cost to the wage-earner for partial health-insurance protection for him and his family. This is practically as much as the estimated cost of complete medical care, including physicians services, hospitalization, complete hospital and home nursing care, immunizations, health examinations, etc., for a whole family, and is 50 per cent more than the average now spent by families with incomes under $2000 per year.

This policy is not intended to cover loss of time. It is supposed to take care of major or serious illnesses or injuries only, and does not pretend to cover the myriad of office calls for minor complaints, which many patients make in the course of a year. Whether this much protection is worth what it costs, or not, is a moot question. A big criticism seems to be that persons who buy this policy do not know for sure how much coverage they really have, and think they are insured for complete medical care when they are not.

Medical Attendance and Hospitalization Policy

The policy used as an example of this type of insurance coverage was originated especially for competition to policies sold by various "hospital associatinns" and "hospital service" groups. As the name indicates, it is intended to cover medical attendance and hospitalization costs in event of injury or illness.

Part A provides for payment of $5.00 per day for each day of hospital confinement, not to exceed a total of thirty days in any twelve consecutive mmnths. $2.50 per day is paid for any confinement after

the first thirty days, but not to exceed one-hundred and fifty additional days. Further, $25.00 is allowed for anesthetic, laboratory, operating room, X-Ray, and ambulance service expenses.

Part B provides for payment of surgeon's fees up to certain limits set in a fee schedule. For example, $50.00 is allowed for surgical repair of a hernia, $75.00 for any abdominal operation, $100.00 for a craniotomy, $20.00 for a tonsillectomy, $5.00 to $30.00 for reducing fractures, and $5.00 for opening abscesses.

Part C allows for payment of $3.50 per day for the attendance of a registered nurse.

Part D provides for payment of the physician's bill. Here, $4.00 is allowed for each call which the doctor makes on the insured, while his patient is confined within the hospital, and $3.00 is allowed for each call made while the insured is confined within doors, but not in a hospital. However, payment for physician's fees will be made for not more than one call per day, nor more than three calls per week, nor for more than fifty calls in the aggregate, as the result of one disability, and only if the insured is continuously confined within doors or within a hospital and only after the insured has been confined for the two preceding weeks and has received three previous medical treatments.

This policy is very similar to the worker's policy discussed in preceding pages. It differs in that it is a little more expensive and a little more restrictive. The cost is $33.60 per year per person. This is about the cost of complete medical care under

a wide-spread insurance scheme as estimated by most authorities. This policy does not provide for complete medical care as can be seen by reading the last sentence of the preceding paragraph. Benefits are paid only "after the Insured has been confined for the two preceding weeks and has received three previous medical treatments." Of course, relatively few persons have an illness lasting over two weeks. As a matter of fact, the insurance firm is betting that the average policy holder will have an average of less than one such illness per year.

So, it's the old story again. A large number of well people are paying the bills for a very much smaller number of sick people. The average person, then, could better afford to carry his own health insurance, except that someone time he might get caught with quite a large bill for medical care and be unable to meet it. The average person will not lay aside $33.60 per year for potential health bills, and so will always be unprepared unless he has insurance, even though in the great majority of years, he would not have to spend this amount for medical care. For example, one hundred policyholders under this plan would be paying in $3360. per year. Their collective medical care bills for any one year would never be as much as $3360 (the insurance company has of course loaded the premium rate to cover expense of promotion and selling, office expense, and other overhead expense), but the bills for any one or several of the individuals comprising this one hundred policyholders might be for in excess of $33.60 in any one year, and the bills of many more other policyholders would

be less than $33.60 apiece. No one can foretell who will be how sick and when, but insurance companies can tell about how many will be sick in a large group, and about how much that sickness will cost in any given year.

Policies for Workers in Hazardous Occupations

These policies are each constructed differently and have a different rate according to the occupation of the insured. The general plan of the policy is similar to those previously described, with provision for specific accident benefits and loss of time. The rate is of course higher the more hazardous the occupation. There is also an adjustment made within each industry. For example, if a large group of employees of a certain mining company are insured and the employer is proven to have advanced safety devices in operation and if the claim incidence is low, then this group can buy their insurance cheaper than a similar group in the same industry who have a higher claim incidence, and at a rate only slightly higher than workers in the common "non-hazardous" occupations.

Special Policies

Anyone may purchase a policy covering a certain specific accident. For example, a golf caddy might wish to be insured against getting struck by a golf ball, an ocean traveler against drowning, an air traveler against death or injury in an airplane accident, and, almost anyone might wish to be insured against death or injury

in an automobile accident. The rates on these policies vary considerably according to the risk insured. They have a value restricted sharply to small isolated groups of persons.

Group Insurance

In addition to the types of policies just discussed, some health insurance companies write a low cost hospital insurance policy on whole groups of persons without restriction. That is, a firm employing a large number of persons is approached and all employees are offered a policy, provided at least 75 per cent of them participated. The payments are deducted from the payroll. In this way, any employee can get insurance coverage regardless of his previous medical history and at a rate much cheaper than any one person could buy the same protection individually, largely because the insurance company is saved the expense of promotion and collection and also because the contracts stay sold. The cross-section is large enough that the company can be fairly certain as to the average state of health or probability of disabilities in the whole group over a long period of time.

A typical example of such a policy provides for $4.00 per day hospital allowance, up to $20.00 for anesthetic, X-Ray, and miscellaneous expense, and payment of surgeon's fees according to a schedule similar to those given before.

This particular policy is written on anyone up to age of seventy, and includes hospitalization for childbirth or miscarriage, and is

non-cancellable so long as premiums are paid regardless of the number of claims of the insured. It does not cover accident or injury sustained while doing anything pertaining to occupation or employment for remuneration or profit, or any accident or injury covered by Workmen's Compensation Laws.

The cost of this policy is only $1.25 per month or $15.00 per year, considerably less than the cost of the Hospitalization and Medical Care Policy described before, partly because of the reasons given in the preceding paragraph, and also because there are not quite so many benefits. Oddly enough, most of these policies, such as this one, make provision for payment of a surgeon's fee, but make no allowance for payment of the internist or other specialist. The tools of the internist are certainly as sharp and more often used than the surgeon's tools, but they are perhaps not so obvious or dramatic in the laymen's eyes.

Critical Summary

Some criticism of the health insurance offered by commercial insurance organizations has been given in the discussions of the various types of policies in the preceding pages. At the risk of some repetition, the most important of these are here briefly summarized:

1. Commercial individual health insurance must be <u>sold</u>, it is not bought. The expense of advertising, promotion, selling, and overhead costs materially increase the cost to the insured beyond

the actual worth of the benefits offered.

2. The responsibility for making regular payments and keeping the insurance in force is left entirely up to the Insured, and the great mass of persons cannot bear this responsibility, as evidenced by the fact that from 50 to 80 per cent of all health insurance written in any one year is cancelled by non-payment of premiums in the second year. This point is even better illustrated in life insurance, a far more stable and uniform field, in which the average duration of a policy is only seven years. The great majority of persons simply will not pay for something they can't see, or at least, they won't keep on paying for it even after they have bought it.

3. Commercial health insurance can never cover the lower income groups because these groups do not have money with which to pay premiums. Even the economic groups which are just within the self-supporting level cannot buy insurance which will give them complete protection at a cost they can afford to pay.

4. Many policies are cancellable at the age of fifty-five to sixty-five, and in many more benefits are reduced as the insured advances in age. A person who pays in while he is young and healthy and should be building up a reserve loses his protection when he gets older and needs it most. Underwriters answer this by stating that each policyholder gets value received each year and can quit even anytime, just like fire insurance--if you never have a fire, you have forever lost all you have paid in, but the protection and

and security is worth the cost.

5. Only a very few policies written by commercial health insurance companies cover housewives (other than straight hospital insurance) or in any case cover diseases peculiar to women. Here is a very significant segment of the "Cost of Medical Care" for which some more adequate insurance provision should be made.

6. In practically all policies, the accident benefits are emphasized and the benefits for organic illness or disease play a minor role, although the latter constitute a larger part of the total costs of medical care. This unequal and unbalanced distribution too often gives the Insured a false idea that he has complete protection, when actually he has not.

7. Non-coverage of venereal disease, diseases peculiar to women, insanity, or mental infirmity, and a six-months waiting period on tuberculosis and heart disease are apparently necessary restrictions from the standpoint of the insurance company, but they do leave a large gap in insurance protection against the total costs of medical care.

8. No benefits are paid for any illness unless it is totally disabling, a few policies excepted in which partial benefit is paid if the illness is disabling only for <u>important</u> work. Therefore, commercial health insurance does not give protection against the cost of the great number of disease processes which require expert and often frequent medical attention, but which nevertheless are not totally or even partially disabling, at least in their early stages.

Along this same line, no provision is made for periodic health examinations, which are certainly necessary if morbidity and mortality rates are to be materially reduced.

9. Only a few states have enacted adequate legislation governing health and accident insurance companies. There are literally thousands of "fly-by-night" companies selling worthless policies, direct and by mail, to the gullible public. These companies have no reserves and do not pay a fraction of the extravagant benefits they claim they will pay. Their policyholders are deluded into the belief that they have "complete protection against all the costs of medical care." As a matter of fact, in most states, anyone who has $100 can start a health and accident insurance company and sell almost any kind of a policy to anyone. All he has to do is to get a permit to show that he has at least one hundred policyholders who have each paid a premium of not less than $1.00.

10. Present figures indicate that a disappointingly small percentage of the population is covered by commercial health insurance. It is estimated that there are only about ten million persons now covered by commercial companies, and if we add to this number the approximately five million persons who have hospital insurance under one of the "hospital service plans", we still have a very small percentage of the total population protected.

11. Nearly all commercial health and accident insurance policies are cancellable on any anniversary date of the policy. This

frequently leads to abuses by the insurance companies in that a person who presents evidence of a chronic or latent disease process too frequently gets his insurance policy cancelled as soon as the company discovers it, often even if he has not presented a claim, and especially if he does claim some disability benefit. The experience of many companies in writing non-cancellable policies has been disasterous. The reason was that rates were computed for young, relatively healthy individuals, and when their average age became greater and their incidence of illness and disability higher, insufficient reserves had been accumulated to pay the increased claims. It is necessary, on a actuarial basis, for the cost of a non-cancellable policy to be quite a little greater than the cost of a cancellable policy, and people will not pay the increased cost. Too often, the purchasers are ignorant of the difference in the two types of policies, or at least fail to appreciate the difference, to their later sorrow.

12. Only one commercial health insurance company writes a policy with an unlimited benefit. All other companies place a limit on the total aggregate benefits which will be paid. For example, if the aggregate benefit is fixed at $5000, and the insured receives a benefit of say $500 one year and $1000 the next year, then the total potential value of the policy is only $3500 thereafter, but the insured keeps on paying the rate for a $5000 policy. This seems unfair.

13. Many of the faults and defects of commercial health insurance contracts as noted above cannot be corrected for obvious reasons.

If some were corrected, then others would appear in their place. Health insurance underwriters are still experimenting with various types of policies in an attempt to meet new demands and needs. In most cases, they have had no previous standards by which to judge the charges and benefits which they should make, and they should perhaps not be criticized too severely for some of their mistakes.

Insurance against the costs of medical care per se, and particularly against the cost of physicians' services, is a very new idea. There has been no demand for such insurance from commercial firms until the last three or four years. So far, no satisfactory policy covering this risk has been formulated. Cooperation between commercial insurance organizations and physicians with further education of each group and the public as to the cost and nature of the services to be rendered is needed.

Compulsory Health Insurance

It is argued that even if we were to have a maximum development of group practice and group prepayment organizations and medical cooperatives and hospital insurance plans, such as have been described in preceding pages, still the problem of delivering adequate medical care to all the people would not be solved. As long ago as 1932, the Committee on the Costs of Medical Care foresaw that families with low or irregular incomes, persons employed in small businesses, and the self-employed would still be unlikely to enter these voluntary plans. The Committee observed that making membership in a sickness scheme obligatory for large groups of persons would increase the population served and also reduce the administrative cost of securing and retaining members. The Committee, however, would not take the last step and recommend compulsory health insurance for the reasons that (1) "the ultimate results will be far better if experience with actuarial and administrative details, and above all the evolution of group practice units capable of rendering rounded medical service of high quality, precede the adoption of any compulsory plan by a state as a whole," and, (2) "a considerable experience with voluntary insurance will be required before public opinion will support the passage of compulsory health insurance legislation."

Almost all the proponents of compulsory health insurance believe that all families with incomes under approximately $3000 a year should be covered by such a plan. They would have the government or its various

relief agencies "carry" the insurance for the unemployed and indigent, and would permit families with incomes from $3000 to $6000 to enter the scheme on a voluntary basis. The lay writers all advocate cash benefits or compensation for sickness as an intimate part of the medical care plan, but even physician-proponents of a compulsory health insurance plan insist that the whole compensation problem must be divorced from the medical care problem itself. All proponents are agreed that controlling bodies must have as members representatives of the state, employers, insured persons, and professional men. This, of course, always leaves physicians in the minority, although they would have to carry the whole burden of application of the benefits.

The Administration's idea about the cost of a compulsory health insurance plan has been given. It is most conservative, or radical. Authors of various plans estimate their cost at from 3 to 6 percent of a worker's wages, or from seventy-five cents to $1.50 per week for a worker with a weekly wage of $25.00. Most plans provide that the employee, the employer, and the state shall share the cost; the state, of course, taking care of the unemployed alone. They say that the employer will benefit greatly because the improvement in the worker's health will mean reduced labor turnover and greater efficiency, the employee will benefit because he is the recipient of better medical care at a lower cost, and the state will benefit in the long run because of the elimination of waste, better health of its citizens, and decreased crime, delinquencies, and number of

public charges.

The Committee on the Costs of Medical Care did not recommend compulsory health insurance in its final report, but the majority believed that it would eventually be necessary for the following reasons:

1. Most European countries, after considerable experience, have gone from a voluntary to a required system of insurance. They perhaps had rather have started out with a compulsory plan for many of the evils of a voluntary plan have been carried over, particularly private commercial interests, and remain to clutter and confuse the administration of a compulsory plan.

2. Voluntary insurance will never cover those who most need its protection; namely, the unorganized, low-paid working people group, who are not indigent but live on a minimum subsistence income.

3. Compulsory health insurance would not antagonize but would stimulate the development of organized medical groups and result in economic and professional benefit to all, with higher standards of medical care.

4. Required insurance will undoubtedly be simpler and more direct to administer and, in the long run, more economical.

5. Governmental participation and regulation will undoubtedly be almost as necessary for voluntary as for compulsory insurance, if the worst abuses are to be avoided. Such participation will be more effective if it is started in the beginning.

The question of whether American needs compulsory health insurance or not was discussed on a recent (January 22, 1940) radio broadcasting program--the "Town Meeting of the Air." The affirmative was expressed by Dr. Henry E. Sigerist, Professor of the History of Medicine in Johns-Hopkins University; the negative by Dr. Terry M. Townsend, President of the Medical Society of the State of New York, and a middle-of-the-road attitude by Dr. C. E. A. Winslow, Professor of Public Health in Yale University. As these are nationally

known and recognized men, and as each is not speaking for himself alone but for a large group of like-minded persons, a brief digest of their views is given here, not only for interest, but for instruction. The particular program on which they spoke is very widely listened-to, and their views have no doubt not only stimulated a lot of thinking along national health lines, but have also influenced the opinions of the listeners in no small way.

Dr. Sigerist first defined health insurance as "a method to finance medical services." Since we have accepted the principle that a wage-earner should have a system of insurance to provide compensation for loss of wages in times of unemployment due to economic crisis, there is no reason why we should not include unemployment due to illness, according to Dr. Sigerist. The principle of insurance is to spread unpredictable risks among as many persons as possible, and voluntary schemes work alright except when the groups are small or very poor and cannot carry the burden, and then they are unable to provide enough benefits. Dr. Sigerist also gave a nice boost for the Capper Bill, which provides that medical services shall be financed jointly by employee, employer, state and federal governments, with compulsory insurance for wage-earners--except agricultural laborers--up to an income of about $3000 a year, and voluntary insurance from $3000 to $5000 a year. He said that if the funds were merely used to pay for the haphazard medical services people have been and are still getting, the plan would probably fail, but if the funds were used to finance health centers which would

provide not only family doctor care but hospitalization and specialists' care as well, then the plan would succeed. He admitted the danger of a top-heavy beaurocracy, but believed it could be avoided by paying health center doctors a definite salary, instead of following the English panel or other European systems. According to Dr. Sigerist, a salary would not cause the doctor to lose incentive, as witness the Mayo Clinic and others. Political interference would be a real threat, which could be largely avoided by making health insurance funds a separate non-profit corporation managed by a board of directors representing all parties concerned, with the physicians themselves controlling exclusively the strictly medical activities. He did not think the personal doctor-patient relationship would suffer much under his scheme.

Dr. Townsend, of course, represented "organized medicine." He said "no" to compulsory health insurance on the grounds that Americans abhor compulsion and would not accept it, that it is not insurance at all, but a sickness tax, that the administrative costs would require a substantial part of all funds collected--probably 10 to 20 per cent, and that politics could not be kept out because of the tremendous clerical help which would have to be hired. As to paying the costs, the workman would just receive less wages, the employer would pass his contribution on to the consumer--who is also the workman--and the already tax-overburdened state would further tax its citizens for the share which it contributed. "Such a tax is discriminatory and inequitable, since it cannot be levied on the unemployed

and the self-employed, the latter including the professions, storekeepers, farmers, artists, writers, musicians, and many others; they must bear the burden of the generally increased taxation, but receive nothing from sickness insurance," said Dr. Townsend. He gave the following quotation from Mr. J. George Crownhart's essay, "Looking at Health Insurance Abroad:"

> "Compulsory sickness insurance is sold as a social service, but its operation as an insurance plan defeats this end.
>
> Its beneficent intent is accepted as a guarantee of a quality of service, that, because of its operation, it is increasingly impossible to render.
>
> To insure a balanced budget requires a control over the medical service that is rendered the sick; such control is excerised in every country where compulsory sickness insurance is existent, and it is not in accordance with our concept of sickness care.
>
> It is sold in its preventive aspects, but its budget and operations reduce medicine to the role of salvage."

Dr. Townsend further stated that the patient looked to his physician for aid, for alleviation of pain, for hope, for advice, and for consolation, and that it was a personal responsibility to be borne by a living being--"the state cannot accompany the doctor across the threshold of the sick room; it is no function of the public health services to practice medicine." He said, finally, that "the medical center of the world today is in America and has been developed by the system as we now know it. Our job is to improve it, not to abolish the system by substituting another. Compulsory health insurance is a mark of decadent medicine everywhere that it exists."

Dr. Winslow, in his talk, was much more cautious in his language

than either of the other speakers. He said that there was one large group of people who needed health insurance, but not necessarily compulsory health insurance, that voluntary insurance was doing and could do the job for these people, but that there was another large group who could not even pay the average cost of medical care and so would have to be covered by compulsory insurance, to which employee, employer, and government contributed. He said that we must be careful to provide a place for voluntary group service by exempting from the working of the compulsory law those groups already provided for under a voluntary plan with services equal in amount and quality. As for the indigent, he believed that tax levy would be the only answer. "In other words," said Dr. Winslow, "there is no single answer. For various sections of the population we need individualistic medical care; we need voluntary insurance; we need compulsory insurance; and, we need an expansion and a far better organization of tax-supported medical care for the indigent in our cities and for the population of our rural areas."

Dr. Alan M. Butler, in a speech before the United States Public Health Association recently, said that he believed that "fee-for-service" and tax-supported medicine were incompatible. That is, we could not have physicians rendering service to patients and have them paid a fee for each service by a third party--the government, according to Dr. Butler. "One reason is," he said, "that such a system leads to malingering and faking by the patient and prolonging and exaggerating treatment by the physician (in many cases.) Another reason is

that such a plan is extremely uneconomical because of lack of organization, duplication of overhead costs, and excessive amount of clerical work." Dr. Butler said that he believed that we needed more voluntary prepayment groups properly organized in order to gain experience and get some standards of cost before we started on any legislation. He also believed that these groups could and should be organized around and by the larger hospital staffs, using the hospital as a nucleus with which to start.

In any discussion of compulsory health insurance, reference is inevitably made in some manner to the English system. Each writer claims to have the real inside story on the English plan. The British medical association is widely quoted as being heartily in favor of the system, as being unalterably opposed to it, and as being indifferent to it. It is claimed that under this system, the physicians are better paid, that they are paid much less, and that their pay has remained the same. It is highly touted as a shining example of just what we should do in America by some writers, and as a shining example of just what not to do by other writers. It is difficult to decide just what to believe in the face of all the conflicting reports.

One thing is quite certain, and that is that the "brother" societies of the British Medical Association in England's various Dominions and Colonies do not want any system even remotely resembling the panel system now in effect in England. Various writers and the organized medical groups in Canada have stated this repeatedly.

In Australia, the President of the Queensland Branch of the British Medical Association stated just last year that the general standard of practice in Australia was definitely higher than in England, and that the English system was not a desirable one for them to adopt because in the panel system "most of the work is done in a hurried way with reliance on snap diagnosis and the fact that the patient will come back if unrelieved on the first try; such a system leads to a high degree of skill in rapid spotting, but what a prostitution of modern medical teaching!" He also stated that he believed it was not the size of the capitation fee which had mobilized medical opinion against the proposed National Health Insurance Scheme, but the deterioration of the quality of service which would certainly occur. Another prominent Australian physician stated that the general practitioner in England had drifted into the position of a clerk who kept records and sifted the sick people to hospitals or specialists. This attitude of such close "relatives" of the English should be significant to anyone who is thinking of using the English system as a model.

Another great defect in the British system, it seems to the writer, is that the financial emphasis is still placed primarily on dompensation of the insured for income lost on account of incapacity to work, rather than on restoration of his health.

The standard benefits claimed by proponents of a compulsory health insurance system are: (1) The removal of the financial dread of illness; (2) the early diagnosis and adequate treatment of the

majority of ailments; (3) the greatly increased equality or fairness of distribution of the cost of sickness; (4) the general improvement in community health resulting therefrom; (5) the statistical data so obtained of use not only to the medical fraternity and through it to the people, but the particular and immediate value in demonstrating to all the crying need of better housing and stricter public health regulations, particularly in certain cities and districts; (6) medical attention to those not now in a position to obtain such attention; (7) a feeling of greater financial security among a very large percentage of physicians who know that every time they are called on a case, they will be sure to receive at least some fee and will also be paid for participation in certain public health services; and, (8) eventually, a hospital bed for every patient who requires it, whether for treatment or diagnosis.

The standard defects claimed by antagonists of a compulsory health insurance system are: (1)There is no decrease in the cost of medical care; the system adds a staggering administration cost; (2) public health and preventive medicine are not assisted or advanced; (3) morbidity and mortality are not reduced; (4) the problem of so-called catastrophic diseases is not solved; (5) over-medication is encouraged; (6) the burden of cost is distributed over the low income class, which is least able to bear it; (7) medical care for the indigent is omitted; (8) graduate education is not encouraged and is usually omitted; (9) the hospital load is increased and hospitals are encouraged to practice medicine; (10) attention and financing are concentrated on the less essential health and medical measures; (11)

diagnosis and treatment are mechanical and superficial; (12) medical service becomes a political issue; (13) the control of medical service is placed in the hands of unqualified, non-medical individuals and organizations; (14) the essential direct personal confidential relationship between doctor and patient is not preserved; (15) every system has so limited financial resources that the physician is compelled constantly to keep in mind the financial restrictions on the services which he can give; and (16) abuses by the insured patients make any plan untenable (as evidenced in all the European countries), for it is just human nature which leads the insured to demand that, since he has been compelled to pay contributions, he should seek to get the greatest possible profit out of the common fund, and this element of human nature is entirely uncontrollable under any insurance plan; such a patient will consult the physician if only to get a prescription which supplies him with drugs free, which he would otherwise have had to pay for, and since the insured person does not wish to be "treated like a pauper when the insurance society is rich enough to pay," he demands expensive preparations and specialties.

The Attitude of Organized Medicine

As in any large group of persons, organized or unorganized, and even with common interests and aims and similar points of view, there is a difference of opinion amongst individual members of organized medicine regarding the question of health insurance and various other aspects of the medical care problem. It may, then, be truly said that the statements and opinions expressed by the duly elected officers and controlling bodies of organized medicine are not necessarily those of all the members.

There can be no doubt that the American Medical Association is organized medicine. Therefore, the ideas and opinions related in this section of the paper are largely those expressed by the officers and leaders of the American Medical Association.

The source of the material is chiefly publications of the Bureau of Medical Economics of the American Medical Association, which contain reprints and digests of very many articles written by various members of the medical profession and other well-informed and qualified persons.

Many unofficial polls (conducted almost entirely by laymen) in recent years have tried to show that the number of members of the American Medical Association differing with the policies of the officers and leaders of the organization is disproportionately large.

It is also alleged by certain persons, both within and without the medical profession that the policies given to be those of the

of the American Medical Association are in reality those of a small nucleus of men who allegedly control the Association and do not fairly represent the attitude of the majority of physicians, and further, that Dr. Morris Fishbein is himself the (self-) appointed spokesman for organized medicine and widely publicizes his own theories and ideas. These allegations are not only unkind and unfair, but untrue. Anyone who has read the official publication of the Association for a long period of time, and who has read the literature published by the Bureau of Medical Economics, knows that all sides of the question are presented and conclusions are based upon careful extensive studies of information received from a wide variety of sources. Yes, the opinions expressed are those of a prejudiced group. So, also, are the opinions of every lay writer or organized group or so-called "expert." Who could remain unprejudiced regarding any social reform which would have such a tremendous effect upon the members of their organization?

It is the belief of the writer that the policies expressed in the official publications of the American Medical Association do reflect the opinions of the majority of physicians and will continue to do so until some change is made in the leaders of the organization. The fact that policies are constantly being modified indicates that the spokesmen are reflecting the changing attitudes of the members in a day of fast-moving social and economic reforms.

This brief introduction is given because the reader is no doubt already more or less prejudiced from having followed the discussion

in the preceding pages which has stressed and emphasized, perhaps excessively, the arguments and theories advanced by those who criticize the present method of administering medical care and wish to change it by rather a far-reaching social reform. The reader should pause here for a moment and reorient himself before hearing the other side of the story.

A great deal has already been presented in preceding pages about the attitude of organized medicine toward many changes advocated and attempted in regard to various aspects of medical care. We have seen how organized medicine, and hereafter this term will be used synonymously with the American Medical Association, has always fought any change from the system of private fee-for-service practice of medicine. It has openly fought the many types of group clinics and medical cooperatives which have sprung up during the past ten years, and very bitterly opposed the attempts of some philanthropic "Foundations" to institute new methods of medical care for large groups of low-income persons. The work of the Committee on the Costs of Medical Care, which was done from 1928 to 1932, was at first actively supported by the American Medical Association, but later criticized severely when the Majority Recommendations of the Committee came out in favor of some form of health insurance for the low-income groups. Many of the facts found by the Committee are, however, accepted and widely quoted by the American Medical Association, as they are by most writers, lay and professional. When the Social Security Act was written and passed in 1935, it was largely

due to the work of the American Medical Association that sickness insurance was not included as a part of this Act.

As we are interested here chiefly in recent developments, we will go back only a few years in presenting organized medicine's part of the story, but it is necessary to follow the story for some time, in order to appreciate the fact and nature of various trends followed.

During the years 1910-16, when the first extensive propaganda for sickness insurance arose in the United States, the American Medical Association, instead of adopting an attitude of prejudicd hostility, undertook one of the most thorough studies of the subject that had been made in America up to that time. As a result of this investigation, the House of Delegates in 1920 adopted a resolution in opposition to the institution of any plan of compulsory contributory insurance against illness, or compulsory insurance which provided for medical service to be rendered contributors or their dependents which was "provided, controlled, or regulated by any state or the federal government."

Public interest in sickness insurance almost disappeared during the 1920's, but was revived after the industrial crisis of 1929 and the succeeding severe depression. Again the American Medical Association undertook a study of the situation in the light of the recent developments since its action of 1920. State and county medical societies throughout the nation began an extensive system of experimenting with plans of providing good medical service, on terms which

could be met by all classes of the population, in the realization that a problem of medical care distribution did exist and organized medicine was attempting to find a solution to the problem. Realizing the necessity of guidance in the conduct of such plans and the existence of certain principles essential to the maintenance of good medical service in whatever plans might be undertaken, the House of Delegates in 1934 adopted ten principles designed not only to assist but to encourage component medical societies in the undertaking of such experiments as offered promise of providing good medical service to all sections of the population. These principles, or "ten commandments" as they are often called, provide that all forms of medical care should be under the direct control of physicians, that the patient have free choice of physician, that medical and hospital service be provided separately, that the cost of medical service should be borne by the patient and paid at the time the service is rendered if possible, that medical service be dissociated from cash benefits, and that there should be no restrictions on treatment or prescribing not formulated and enforced by the medical profession.

When it was proposed to include a plan of compulsory sickness insurance under the Social Security Act of 1935, the House of Delegates of the American Medical Association was called in special session to formulate a policy with respect to the proposed legislation. Significant parts of the report adopted at this meeting are quoted here, for they show plainly what the attitude of organized

medicine was at that time.

"The reference committee, believing that regimentation of the medical profession and lay control of medical practice will be fatal to medical progress and inevitably lower the quality of medical service now available to the American people, condemns unreservedly all propaganda, legislation, or political manipulation leading to these ends.

"The House of Delegates of the American Medical Association reaffirms its opposition to all forms of compulsory sickness insurance, whether administered by the federal government, the governments of the individual states, or by any individual industry, community or similar body. It reaffirms, also, its encouragement to local medical organizations to establish plans for the provision of adequate medical service for all of the people, adjusted to present economic conditions, by voluntary budgeting to meet the costs of illness.

"The House of Delegates recognizes the necessity, under such conditions of emergency, for federal aid in meeting basic needs of the indigent; it deprecates, however, any provision whereby federal subsidies for medical services are administered and controlled by a lay bureau. While the desirability of adequate medical service for crippled children and for the preservation of child and maternal health is beyond question, the House of Delegates deplores and protects those sections of the Wagner Bill which place in the Children's Bureau of the Department of Labor, the responsibility for the administration of funds for these purposes.

"The House of Delegates condemns as pernicious that section of the Wagner Bill which creates a social insurance board without specification of the character of its personnel to administer functions essentially medical in character and demanding technical knowledge not available to those without medical training.

"The so-called Epstein Bill, proposed by the American Association for Social Security, now being promoted with propaganda in the individual states, is a vicious, deceptive, dangerous, and demoralizing measure. It introduces such hazardous principles as multiple taxation, inordinate costs, extravagant administration, and an inevitable trend toward social and financial bankruptcy."

At the regular meeting of the House of Delegates in 1935, a

a special report was adopted from which the following paragraph is quoted as indicating the attitude of the American Medical Association on insurance as a method of paying for medical service.

> "There is nothing inherently good or bad, from a medical point of view, in different methods of collection. Insurance, taxation, budgeting, advance financing, and all other methods are nothing more than tools with which to conduct an economic transaction. They remain nothing more than this and can be discussed impartially <u>if they are kept strictly within the economic sphere.</u> The problem is to select the best method for every purpose. The chief thing to keep in mind is that <u>all forms of collection should be isolated from any control of service and be kept exclusively in the economic field.</u>"

It has been stated repeatedly--without the slightest foundation--that the American Medical Association opposed group hospitalization or hospital insurance. When the movement toward such insurance threatened to become a commercial craze and was being exploited by numerous promoters for profit, the American Medical Association did condemn the unsound and dangerous features of such plans, and in so doing, aroused the antagonism of some of the leading advocates of group hospitalization. Some of those who criticized this attitude of the American Medical Association have since admitted that the schemes condemned by the Association were undesirable. In 1937, the House of Delegates adopted principles which were considered necessary to safeguard the quality of medical service under hospital insurance. The principles conform in general to those laid down in 1934, which have been noted above. The test applied was whether the plan as a whole or any of its features would result in lowering the quality of medical service.

The organized medical profession has continuously and consistently urged the creation of efficient, adequately supported public health departments--national, state, and local. It has always used its influence to maintain the efficiency of such departments by excluding political influence and ensuring competent scientific direction. For more than sixty years, the American Medical Association has urged the creation of a national department of health, with a physician at its head to sit in the President's Cabinet. It believes that the present multitude of health activities of the federal government could thus be organized in such a way as to ensure and maintain efficiency in administration and elevate standards of health care in all fields of governmental activity.

The American Medical Association has given more study, over a longer period, to compulsory sickness insurance schemes than the individuals or institutions that advocate such systems of insurance. This study, which has covered all existing systems throughout the world, has led to the conclusion that any scheme by which medical service is treated as a commodity that can be purchased wholesale by governmental or lay organizations and distributed at retail to patients results in a superficial service that delays the conquest of disease and even increases some forms of sickness, and has not been shown to be as helpful as other methods in reducing mortality. Medical service, unlike cash or material commodities, cannot be collected, stored, and distributed without changing its qualities. Its value depends on the relations between the producer (the physician)

and the consumer (the patient). Its distribution is a part of the service. The introduction of a third party who is neither physician nor patient is equivalent to adulteration of service.

As has been indicated in the above paragraphs, the American Medical Association does not oppose the use of the principle of insurance purely as a means of meeting the cost of medical care. If, like all other systems of insurance, it is maintained on a cash basis as to both premiums and benefits, so that there can then be no method by which the cash paid as premiums is transformed into an inferior service which the patient cannot judge, then organized medicine does not oppose such insurance.

So much for the general attitude of organized medicine regarding new reforms advocated in the field of medical care. The next few paragraphs will deal with solutions to the various problems as proposed by organized medicine.

In the past, the principal source of medical care for the indigent at all times has been the gratuitous medical services furnished by physicians in private practice. It is estimated that in recent years such care has amounted to more than $1,000,000, a day, as measured by the fees which would usually be charged for such services. The medical profession does not complain of this gratuitous service; neither does it boast of it. Physicians believe that the obligation to provide such medical care is shared by the profession with the entire body of society.

Prior to 1929, the public contribution to care of the indigent

was principally through salaried county or city physicians. These were often inferior men, selected for their political affiliations, and then overworked and underpaid and subjected to impositions by the recipients of the medical care so gross as to be intolerable--just because it was free.

After 1929, changing conditions, and especially the existence of centers of poverty in large cities and the drouth areas in the farming regions, made it impossible to supply all the indigent with good medical care, however willing the great body of physicians. Accordingly, many experiments were started in an attempt to meet the problem, such as the "Iowa Plan", in which the county medical society assumed the whole burden and divided the work evenly amongst its members, whatever funds collected from the relief authorities being used by the whole group for payment of society dues, library books, and other similar purposes. In other states the physician's incomes were so low that the money collected was reapportioned amongst the members according to work done so that they would have a livable income. The two methods of payment of the physicians by the county authorities were by "Lump Sum Contracts" and by a "reduced fee schedule."

These county medical society plans have been changed and modified in various localities and at various times during the past few years so that there are over two hundred such plans now in operation in the United States. The big problem which has arisen in more recent years is that a very large percentage of the local governments have

gone bankrupt and consequently have not paid any money to any physicians, so the physicians have had to go right ahead with their gratuitous service as before, but now at least in a more organized way.

In many states boards of County Commissioners have used Social Security Act funds to contract with medical groups (any licensed physician _may_ participate) for care of low-income or medically indigent persons on a reduced fee schedule.

Local medical societies have cooperated extensively with the Farm Security Administration, and also some other government agencies, in their plans for the medical care of low-income or destitute farm clients on an annual prepayment basis. This plan has been discussed in previous pages and need not be repeated here.

In addition, to the activities of medical societies concerning medical care for the indigent and for low-income or destitute farm families, they have also experimented with many other arrangements for the distribution of medical services to low-income groups generally. These can be classified into three main types: (1) postpayment plans; (2) prepayment plans, and, (3) credit and collection bureaus. _Postpayment plans_ are more commonly known as "medical-dental service bureaus." These bureaus enable persons in the low-income group to receive medical, dental, and hospital care at rates reduced according to the person's ability to pay, with the payments arranged on an installment basis requiring no interest or carrying charges. The medical-dental service bureaus were, therefore, conceived as a sort of financial counselor to assist the patient in budgeting his me dical

bills and to assist the physician in determining his charges more accurately according to the patient's ability to pay. In places where they exist, all the members of the local medical society participate in the plan, and it is controlled by the society. When a patient applies to the Bureau, he is given an investigation and referred to the doctor of his choice. The doctor diagnosis the illness and obtains the services of hospital, specialists, etc., through the Bureau. All who supply service send bills to the Bureau which are charged to the patient. Out of his weekly wages, the patient pays to the Bureau a small amount agreed upon at the time he applied for service, and his total indebtedness is so adjusted that the period of payments will not exceed one year. The amount is based solely upon the patient's ability to pay. When received, collections from the patients are distributed to the cooperating professional units. In the Wayne County, Michigan plan, for example, the first $25.00 goes to the hospital. Subsequent collections are distributed: Half to the hospital and half to the professional people to furnished service. The Bureau makes a service charge of 10 per cent which comes out of payments to the professional people rather than from the patient. While it is true that the medical-dental service bureaus are postpayment plans and, in effect, mortgage the future income of persons who incur medical, dental, and hospital bills, they do not exact any payments from the patient that are not used in his behalf for services rendered; they do not charge the patient for administrative expenses; they make possible a real reduction in bills for

those who are deserving; and they can arrange for every medical, dental, and hospital service for all classes of patients.

Prepayment Medical Care Plans have received much publicity in the last few years. The medical profession has been widely accused of opposing "socialized medicine" or plans for group payment of medical bills. When the term "socialized medicine" is used in the sense of some arrangement for government control of medical services for individual persons in the general population, it is true that the medical profession objects to such state-managed systems; however, when the term is more properly used to include the variety of arrangements whereby individuals receive medical service without directly paying physicians or without being required to pay at all, such plans are not opposed by the medical profession. Prepayment or group payment medical care plans are of two main types. The first is a unit service plan, whereby an organization is created to collect funds from members and to provide medical services through participating physicians who agree to accept a prorated division of whatever funds are available after administrative and other expenses have been paid. The second is a cash indemnity plan, whereby an organization is created to collect funds from members and to pay a designated amount of cash to assist members in meeting their medical bills. Under the unit service plan, a schedule of the number of units to be allowed for each service is established, and the value of the unit is determined by dividing the amount of money available for medical services, but these restrictions

soon interfer with the physician's judgment as to the requirements of his patient. Also, financial conditions imposed by the limited funds of the plan necessitate the inauguration of practices which are not desirable, such as the use of resident physicians in hospitals to make house calls. Further, the unit system does not allow for differences in ability among physicians of like training. All must accept the agreed number of units at whatever value may be given to each unit.

Cash Indemnity Plans were proposed as an arrangement to avoid some of the difficulties of unit service. In this plan, it is recognized that the benefits to subscribers must necessarily be limited by the fund of money that can be collected, so the cash indemnity plan in the beginning places a definite limit on benefits which it is estimated can be paid out of funds collected. If the benefit is not sufficient, then any unpaid balance must be agreed upon mutually by physician and patient. The faults of the cash indemnity plan are fairly obvious. It is relatively expensive, does not cover possible large medical care bills which a family may incur within a given year, and subjects both physician and patient to the nuisance of a lot of bookkeeping and dealing with third parties.

Credit and Collection Bureaus, the third type of experiment for distribution of medical services to low-income groups, are primarily organized to provide a credit rating and collection service for member physicians, and also frequently arrange for the postpayment of medical bills similar to medical-dental service bureaus.

Some have organized plans to assist patients in financing medical bills. They tend to eliminate, it is said, undesirable features between the physician who has extended credit and his patient. They probably do not increase the scope or affect the quality or cost of medical care very much except in the general proposition that lack of attention to the proper conduct of the "business" side of medical practice interferes with the delivery of good medical service.

The medical profession, contrary to frequently repeated statements by propagandists for sickness insurance and contract medical service systems, has never objected to organized methods of paying medical bills, nor has the American Medical Association ever opposed the principle of insurance for the paying of medical bills. What is opposed is misadministration or manipulation in the application of the insurance principle which results in control over the relations between the physician and his patient and diverts a considerable portion of the funds obtained from members to the maintenance of a bureaucratic organization for activities not directly concerned with the problem of helping sick persons to regain health.

The medical profession has suggested that the insurance principle can best be applied if restricted solely to the payment of medical bills by returning to the insured a specified cash benefit for the services covered in the insurance. In other words, the medical profession does not object to the way the bill is paid, but to the way third parties intervene between the patient who pays, or should pay, the bill and the physician who renders the service.

To a certain extent the question of sickness insurance, and contract practice involves a struggle between lay administrators or politicians and the medical profession for control of the character and method of delivery of medical services.

Both sickness insurance and group contract plans are outstanding exceptions to the general principle of insurance. Fire, life, marine, accident and nearly all other forms of insurance collect definite premiums in cash, for which a definite cash benefit is paid on the occurrence of a specified loss or injury, and this is true of most present commercial forms of health insurance, but most systems of sickness insurance proposed by various groups at this time violate this principle. They keep the premium side of the ledger in cash, but the service side is kept in elements of an uncertain, undetermined service which the receivers of such service are unable to judge.

Although the health insurance premiums at the time they were fixed might be adequate to pay for complete satisfactory service, it would be inevitable that within a few years they would be wholly inadequate. It would then be much easier to reduce the quality of the service by ignoring the advances of science than to increase the premiums.

Organized medicine particularly advocates careful study and planning before any new plan for medical service is introduced. Advocates of wholesale panaceas like compulsory sickness insurance may deprecate plans which cover a comparatively small portion of the community, but that portion may be the only one for which a change

will be helpful while the alleged panacea may bring more evil than good. In other words, we had better experiment with a small plan and later expand it into a comprehensive one than to start with a large scheme involving new and cumbersome administrative machinery.

When the actual facts are sifted from the chaff which has accumulated around the discussion of medical care plans, it is found that the care of the smallest fraction (not over 15 to 20 per cent) of the low-income group is mainly responsible for the demand for special plans in the distribution of medical care. True, nearly all proposed medical service plans focus their attention on families with incomes below $1500 to $2000 per year. This is a large group, and includes about 35 per cent of the non-farming class, and 72 per cent of the farmers, but not all of these constitute or are part of a special problem, for very many such persons are able to pay for their medical care in the same way that they meet exceptional expenses in other lines.

The indigent class is not fundamentally, and certainly not exclusively, a problem for the medical profession. The care of the indigent is a broad social problem, of which the medical care aspect is an admittedly large part. The chief economic difficulty arises at the point where major illnesses are combined with low incomes, for there is no important problem in the care of minor diseases except in the case of the indigent.

The problem of the care of the chronically ill is so largely economic as to be scarcely the main concern of the medical profession.

This problem depends on providing sufficient economic relief to provide all the essentials of life, including adequate medical care.

Neither do institutional cases demand any special new plans for their care. It is only necessary to see that they get satisfactory care in institutions free from political influence.

Preventive care runs across all income classes and many types of illness. In this field, public health, nursing, and the private practice of medicine must combine their efforts. Here, education of the public is of primary importance.

Finally, the American Medical Association concludes that the county medical society is the only organization occupying the natural geographic unit and possessed of the necessary professional knowledge and the power to maintain the Principles of Medical Ethics in the organization of medical service in a community. These features place county medical societies in a strong strategic position to organize medical service and to become the center of medical activities within the territory they cover. The county medical society is not only the logical unit on territorial and professional grounds, but it is also, by tradition and discipline, founded on the basis that "reward or financial gain shall be a secondary consideration." It cannot legitimately be organized for profit. It must be devoted as much to the constant improvement of the services that the medical profession can render to humanity as to the interests of the profession itself.

Conclusions

1. There is no question but that, for one reason or another, a very large number of persons in the United States today receive inadequate medical care. These persons are to be found chiefly in the indigent and "medically indigent" classes.

2. It is also true that persons in lower middle-class families (with annual incomes up to $2500) are faced with a medical care problem in that they can finance ordinary minor illnesses, but are always potentially liable to marked economic unbalance in case of sudden disabling major accident or illness, particularly if hospitalization is involved.

3. It is further true that preventive health services for the nation as a whole, particularly immunisation programs and periodic health examinations, are entirely inadequate at present.

4. Entirely insufficient provision has yet been made for the care of chronic illnesses, such as tuberculosis, leprosy, certain forms of arthritis and heart disease, and mental diseases.

5. Social legislation in the form of Workmen's Compensation, unemployment insurance, old age insurance, farm relief, direct relief, and the care of the blind, the crippled, the widows, the orphans, the soldiers and sailors, the disabled war veterans (with disabilities resulting directly from combat service), and the care of the permanently disabled constitutes a special economic problem which must be kept entirely separate from any system of general

medical care. So, also, must the factor of compensation for loss of time due to illness be kept entirely separate from the system of general medical care. The latter had better be administered through the present unemployment insurance bureau.

6. Systems of medical care which now exist in certain industries or within certain large corporations, which are proven to be adequate, efficient, and economical, should be maintained in their present status at the option of their members.

7. The present work of the Public Health Departments in cooperation with local organized private physicians (County Medical Societies) should be continued and expanded in the fields of venereal disease, maternal and child health, the common communicable diseases (including immunizations, prophylactic and therapeutic serums), and community and industrial hygiene. The financing of these increased public health services must be done by the federal government and the state through state and local health bodies which should be made up primarily, but not exclusively, of physicians.

8. The care of certain chronic diseases such as tuberculosis, leprosy, certain forms of heart disease and arthritis, and mental diseases (including largely the major psychoses) is largely a public problem. Increased facilities, particularly in the form of sanitoria, are needed to adequately care for these cases. The necessary funds must be supplied by the federal government and the individual states, to be administered by state bodies, such as the respective State Departments of Health, in cooperation with physicians generally

through their organizations--the State and County Medical Societies.

9. Construction of new general hospitals should be begun slowly and only after a thorough study of each locality's needs has been undertaken by a competent group, and only after existing hospital facilities have been maximally utilized. Where the need does exist, the federal and state governments may be utilized as creditors to finance the construction by means of long-term loans to local, public-spirited, non-profit organizations.

10. The American Medical Association is to be commended for its unselfish attitude toward the problem of medical care for the indigent and medically indigent groups, and for its exhaustive studies and experiments on possible solutions to the problem. Other organized groups, and the administrators of government, are also to be commended for their interest and recognition of responsibility in this problem so important to the national welfare. The fact that no completely satisfactory solution has yet been found is certainly not for want of trying.

11. There has always been and probably always will be a more or less large group of indigent and medically-indigent persons in this country. It would seem wise to set up a long-term or permanent but flexible program to provide for the medical care of these people, rather than to try to take care of them by year-to-year varying legislation. The logical and sensible basis for such a program is the application of the insurance principle, that is, spreading the costs over large groups and long periods of time. Commercial insurance

can never reach these people because of its cost and limitations of service. Even non-profit hospital insurance can serve but a very small percentage of this group, and only solves about one-fourth of the problem when it is applicable. Cash indemnity plans, as advocated by the American Medical Association, certainly cannot be applied to these people because, by and large, they cannot contribute any cash to the plan, and should receive none with which, theoretically,to pay for medical care. The present system of taking care of such persons, in which services are unorganized, inefficient, uneconomical, and inadequate in scope, is obviously not only unsatisfactory, and a deteriment to the national welfare but grossly unfair to physicians who must carry a very large part of the burden on their own shoulders. The insurance method seems to have the fewest defects. A compulsory form of insurance would have many advantages, and many disadvantages. If such a plan were introduced to take care of the lowest income groups or even for the medically indigent alone, it would not be long until organized pressure groups, such as organized labor for example, would be clamoring to be included in the plan, and the income level below which persons were included would gradually rise until all the population was covered by such insurance. The result would be a system of state-controlled medicine. If personal liberties were sacrificed to attain the end of complete medical care for all persons, then it would become impossible to retain any personal liberties and our present form of government would be lost. The insurance plan, then, must be organized within the various in-

dividual state governments, using tax monies to care for the indigent with optional participation for those who could afford to pay the premiums. True, this would not entirely eliminate the element of politics, but at least it would provide for better and more economical planning and organization than now exists. Although indigency would have to be defined in each locality, the administrative and financial elements would have to be provided through a state agency, for local and county governments are subject to too much variation in their financial sufficiency to provide the long-time stability which is necessary. Remuneration of physicians should be through a mutually agreed upon fee-schedule.

12. Payment of physicians for services rendered to indigent persons would not solve the whole problem. If physicians could only collect their due from persons who are normally able to pay for the cost of services, their load would be very materially lightened. Some plan must be devised to make it easier for these people to pay their medical bills. If reliable commercial insurance companies and physicians would cooperate in working out a satisfactory minimum fee-schedule, so that the insurance companies would have definite costs upon which to base actuarial computations, and if the public were educated as to the benefits and cost of insurance to cover adequate medical care, a large part of this particular problem could be solved in this way. Commercial insurance companies cannot economically insure petty claims, just as, for example, a bank cannot make a loan of $30.00 at a reasonable rate of interest which will

be satisfactory to both creditor and borrower. The cost of making many small transactions is too great in relation to the benefit offered. So, also, would it be impractical for insurance companies to insure only claims of over $50.00, for example, such as is done in automobile insurance. It would then be only human for physicians to elevate the costs of their services to insured persons so that they fell within the range of insurance benefits. A better plan would be for the insurance company to insure against the costs of medical care up to a definite limit, as set by a fee-schedule, and then allow any greater charges to be adjusted strictly between the physician and patient. In this way, the physician would be able to collect at least a minimum fee, the patient would receive an adequate amount of medical care, the doctor-patient relationship would not be disturbed, and there would be no sacrifice of personal liberties to the State.

13. A complete solution of the problem of the distribution of medical facilities and services to everyone is not immediately possible. The nation as a whole certainly is not yet prepared for the introduction of any far-reaching health insurance scheme such as is recommended in The National Health Program. We cannot discard a system of medical care which has produced in a relatively young nation the highest general level of health and best quality of medical service which exists in the world today. That it is not perfect is not a valid reason why it should be discarded. Unquestionably, more study and experimentation by all parties concerned, and a wider

use of existing facilities such as are offered by commercial insurance companies, hospital service organizations, and local medical societies is indicated before any decisive legislation is enacted. When the time does come for a definite change, it should be gradual and progressive with adjustments regulated to serve ever-changing conditions.

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