UNIVERSITY OF CINCINNATI

June 1 1953

I hereby recommend that the thesis prepared under my supervision by Charles W. Asbury, M.D.

entitled THE HIDDEN RESPONSIBILITIES IN THE ADMINISTRATION OF HEALTH AND WELFARE PLANS BY INDUSTRY

be accepted as fulfilling this part of the requirements for the degree of Doctor of Industrial Medicine

Approved by:

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Form 668—G.S. and T.C.—1M—4-51

THE HIDDEN RESPONSIBILITIES IN THE ADMINISTRATION OF HEALTH AND WELFARE PLANS BY INDUSTRY

A dissertation submitted to the

Graduate School of Arts and Sciences
of the University of Cincinnati

in partial fulfillment of the
requirements for the degree of

DOCTOR OF INDUSTRIAL MEDICINE

1953

by

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M.D. University of Cincinnati 1942

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PREFACE

Voluntary health and welfare programs are now accepted among the social advances in the United States. However, on the whole, economically, there has been neither progress nor advancement; for adequate health maintenance today is offered less efficiently and at a higher price than at any time in history.

In the purely medical sense, a small proportion of the population obtains adequate medical care. For as medical practice continues to progress, disease, illness and injury are accepted as total losses which should be prevented. However, no acceptable positive plan for preventive medical care has been proposed for the people of the United States.

Adequate health maintenance has become a sociologic and economic puzzle. In the confusion that exists, although prevention is preached, it has not been practiced. For example, as the problems of health maintenance are being solved, the proper emphasis is not being placed on the preventive phases of medicine. Instead, the efforts of all disagreeing factions are being exhausted in an attempt to justify the cost of therapeutic medicine, which, through medical progress, is becoming less and less of a problem.

The matter becomes more confused when the interested groups realize that the existing problems of medical care must be solved with great caution. For the future of the entire economy of the United States may depend on whether or not the system of health maintenance that is chosen can be operated so efficiently as to be kept within the

limits of a reasonable and supportable cost.

The viewpoint is presented that the situation, as it now appears, is not sound. It does not appear that health and welfare problems are about to be solved in a satisfactory and final manner. Rather, there is reason to believe that the people of the United States have been maneuvered into an unfavorable position, and that if prompt action is not taken to make the present voluntary system more efficient, there will be no other alternative than to accept a compulsory federally controlled system as a substitute.

A capitalistic democracy, such as the United States, must continue to operate on the principles of a system of free enterprise. Private industry is the backbone of this system. It is very nearly the sole remaining source of economic power and social responsibility sufficient to assume the obligation and responsibility of meeting the hygienic problems which confront the American people. It is evident that physicians, generally, act as individuals, and not in concert. The problem requires effective group action, and the doctor, therefore, cannot deal with it effectively.

Three years ago, realizing that the majority of the people in the United States were not receiving adequate medical care and were not being included in health maintenance programs, the author began to consider the ways and means of solving this problem for the employes of small industries. He soon realized that such a project included the need to solve the problems of health maintenance for all groups; and that they could not be solved separately.

The existing problems are those of the local community. However, the administration, organization and promotion of a plan which might solve these problems now are industrial responsibilities and obligations. (Labor groups are here considered to be an integral part of the industrial system of the United States.)

The project then is to propose a stable system of sound health maintenance; a system which will not be wholly prepaid, but will include all the medical services necessary to accomplish good health, yet one which might be financed on a continuing voluntary prepaid co-insurance basis.

The opportunity exists to offer fairly comprehensive prepaid health maintenance to the employed segment of our population and their dependents, essentially through industry. Actually, the people in the United States are not obligated to do more, for a major segment of our population can have good health maintenance through efficiently administered industrial programs. This being successful, it would be just another step to accomplish coverage for that segment of society not employed; assuming, however, that, for such a group, adequate health maintenance is feasible and desirable.

It is the purpose of the following paper to analyze the problems in the field of health maintenance and to establish a solution which might be acceptable to the groups concerned. An analysis is completed in Part I. A solution is given in Part II.

Part I is composed mainly of the opinion and findings of other authors, but certain conclusions have been drawn in each section.

These conclusions are used as a basis for the solution established in Part II. As will be found, no integrated system of health maintenance exists as yet.

PART I

CHAPTER I

THE SOCIOLOGIC AND ECONOMIC ASPECTS OF HEALTH AND WELFARE PROGRAMS

"The speed of present technology has tossed us far out unto uncharted waters. From here on we travel without precedent. Never in history has a society employed a technology approaching that of this nation. What is more significant, its rate of change is still accelerating." (1). This might also be said about health and welfare programs, for in this field there is little precedent for decisions, and changes are occurring rapidly.

Our People as Described by Other Authors

In order that more rapid progress may be made in accomplishing an appropriate system of health and welfare, the characteristics, ideals and desires of our people must be analyzed and applied in an unbiased manner.

Health and disease dictate the destiny of nations as well as individual persons - and indeed of whole civilizations - as history shows (2). Yet the American People are spending but four per cent of their total income for medical care, while a larger amount is spent for alcoholic beverages and recreation. Physician's bills total about half those incurred for tobacco. The people appear to want luxuries, alcoholic beverages, tobacco and entertainment more than they do medical care. (The cost of living has risen 86 per cent since 1939,

while the cost of medical care in the same period has risen 56 per cent.) (3). The demand for medical care has been small in comparison to the demands for other consumer items. It has been small, not because people cannot afford it, but because they preferred to spend their earnings in this manner (4).

When Winston Churchill recently regained power, it was the job of his new minister of health to extricate British medicine from the economic snarl that had come from appearing to promise the people of that country something for nothing (5). As in Britain, if medical care insurance in the United States is to be considered primarily a means for financing the cost of illness, then this belief must go hand in hand with the concept that man is a thoroughly rational human being, completely motivated by self-interest, and fully endowed with knowledge and foresight. These are hardly in accord with the current concepts of human behavior, or with the practices of insurance companies (6).

Work means recognition in our society, and it is largely through work that one gets a sense of being useful as a member of the community (7). However, there are a great many people who find in their jobs a source of dissatisfaction, conflict and anxiety. Others are not conscious of how strong their desire is to live in complete idleness. Perhaps these people have never been taught the necessity for, nor have they experienced the satisfaction to be gained from, work. They have not been indoctrinated during the years of growth and education with the idea of doing a definite job, nor with a feeling of community

responsibility. Such people want a great deal for a minimum of effort and become unhappy if progress is slow or if their ambition is not realized (8).

Further, to consider man as he is today, abuse of privilege and irresponsibility appear to be becoming relatively more characteristic of our society as a whole. "Morally, Americans seem to have lost all regard for the rights of their fellow men. A race for government privileges has become unrestrained. National affairs are no longer guided by any principles, but only by monetary expediencies. Americans, having abandoned principle, are literally enslaving each other (9)."

It is probably partially because of this attitude that our health insurance programs are abused. Labor and management must correct this, in order that a sound prepayment system of health insurance and of non-occupational disability benefits may continue to exist.

Exploring Compulsory Medical Service

Even those most ardent in their desire to have some kind of sickness insurance in this country freely admit that none of the systems in use abroad would do for the American people (10) (11) (153). There is a wealth of experience which shows that under compulsory medical insurance on a nationwide scale, though a large number of people receive medical care, the quality of medical service rendered by individual physicians tends to decline.

After a year's operation of compulsory insurance in the United States (Rhode Island), all participants are reported to agree that the

administrative costs were higher than expected, and red tape was excessive and prejudicial to the quality of medical care; there was need for decentralization of the program (10).

The point at issue is not whether moral abuses can and do exist in the private practice of medicine or in the voluntary group organization of health service, but whether these dangers are not greater if the state imposes a compulsory tax for a uniform health program on all the citizens (12) (13).

Comprehensive voluntary prepaid medical care, on the other hand, has a few ardent supporters. When comprehensive medical care is freely available to all subscribers, as under the Health Insurance Plan of Greater New York, it is found that only nine (9%) per cent of all the medical services are rendered to patients in hospitals and that 90 per cent are provided for the enrollees in their homes, in doctors' offices, in medical centers and in the x-ray and diagnostic laboratories of the medical groups. This, according to Health Insurance Plan executives, points up the inadequacy of plans which provide merely medical expense indemnity limited to economically catastrophic illnesses which require hospitalization (14). Such experience also supports the feasibility of a prepaid outpatient diagnostic service.

The Blue Cross system specifically limits its payments for hospital diagnostic services to those illnesses for which hospitalization is necessary. This provision is abused, and when such abuse occurs, the cost of room and board and fixed "admission" diagnostic services are simply added to the actual cost of the laboratory services

desired. There is no reason to believe that this would not continue under a compulsory comprehensive system.

Other Factors in the Health Development of a Nation

That other factors, beside the financing of medical care, play important roles in the health needs of our nation cannot be overlooked in appraising the future of health and welfare plans. The available evidence does not indicate that the system of financing medical care is a major factor in the health development of a nation. Therefore, one should not assume that the adoption of any system which pays for the cost of medical care, compulsory or otherwise, will, of itself, make for a decided improvement in the health of the people. There is good reason to believe that better results might be expected from paying careful attention to the improvement of living standards, to good nutrition, the elimination of economic and social inequalities between races, development of medical facilities, preventive health measures and other factors which directly affect the health of the people (15) (13).

Population Studies

The stages of population growth are reported to be three in number. They are (1) Pre-industrial, high growth potential in which both birth and death rates are high (Orient), (2) Transition growth period - declining death rate and continuing high birth rates appear-

ing with the introduction of technological advances, sanitation and medicine, and (3) (Incipient) Decline period in which the birth rate falls progressively, producing a trend toward declining total population growth (16).

The United States evidently has about passed through the first two phases. This has been due to a high birth rate, a rapid decrease in the death rate, and heavy immigration. We are approaching the end of this era as is evident from a study of long-term trends in birth and death rates (16). Since the United States may be entering the "decline" period in the growth of population, and since the labor force here may be limited for some time to come (151), it appears advisable to investigate just who might and can be covered in health and welfare programs administered in industry.

There are those who believe that everyone in the United States should be covered with comprehensive prepaid medical care from cradle to grave (17). There are others who believe it neither possible nor desirable that everyone should be included in a common type of health program (18).

The problem of medical indigency also arises in the consideration of proper coverage. It is estimated that "more than six million of the 15.5 million families that receive incomes of less than $2,000 per year (1948) are medically indigent." Many of these six million families would not qualify under compulsory health insurance and could not pay its costs in the form of "earmarked payroll taxes." (19). A voluntary or compulsory health insurance program would not improve the

health of this group if the basic problem is the lack of income for other necessities that are just as important as medical care in the maintenance of good health. Therefore, furnishing medical care without cost to this group may not solve their health problem; yet it could create others. The expense of such coverage would add to that now involved in provision for the medical care of the indigent, who need to have other necessities supplied to them to maintain their health.

To consider further the problems that are inherent in population studies, an accepted goal for prepaid health insurance is coverage for 100 million people (20). Why should not this figure be 150 million people? It may be because 25 million people already receive care in part or entirely from the government. In addition, indigents are theoretically not to be included in the suggested compulsory health insurance program - they number another 5 million. There are about 10 million who are not interested in obtaining professional medical care (religious groups and patients of drug stores and faith healers, etc.). And lastly, there are about 10 million people for whom the cost of medical care is not an economic burden (20).

The Geriatric Problem

It is perhaps not too much to say that our aged population is the real "health crisis" of today (21).

The situation we face is this: in less than thirty years about 66 million people in this country will be 45 years of age, or older,

and of this total, at least 20 million persons will be 65 or over. Being old is a major cause of poverty in the United States. Of the four million families with incomes below $1,000 yearly, 32 per cent are headed by persons of 65 or over (7).

In older people, security becomes a major objective. Some older people would sacrifice certain accepted principles to have their future guaranteed by law. Older people need income, not medical care alone (22).

As the proportion and number of older people increase, the associated problems increase (23) (150). Of these, the foremost is the greater incidence of chronic diseases which do not terminate quickly in death; for the percentage of impaired and disabled individuals increases directly with age (16) (23). Moreover, in addition to physical disability, there are the serious emotional disturbances in old age. Senescence is often characterized by frustration, bitterness and other manifestations of physiological and sociological maladjustment. Ideally, old people should be kept physically well, mentally alert, energetic and vigorous (16).

It is evident that geriatric problems need attention; but as we move toward a solution, the effect that old age security measures and other economic provisions might have upon the younger generation must be considered (21).

Looking at Labor

Labor groups in the United States have recognized and reported

the need for improved programs of medical care. They have played an important part in the establishment of the changes that have been made in the health and welfare plans. However, if the problems confronting all of the groups affected by health and welfare plans are to be solved satisfactorily, the policies advocated and applied by labor groups must be studied in an unbiased manner.

Anyone who has bargained with labor individually and then collectively through its representatives is soon made aware of the differences in bargaining practices and theories. Indeed, the force and direction of union demands are so new and novel to many, that unions have been viewed by some, not as an economic institution, but rather as a political mechanism. Certainly the efforts of some labor leaders to perpetuate themselves in office, to support discredited economic theories because of their apparent appeal to workers, and to participate actively in the election of government officials, lend support to those views (24).

The behavior of any group of people makes sense to that group, no matter how irrational it may appear to any or all other groups. Any form of behavior will continue, no matter what the pattern is, as long as it is rewarded, and whether the group be six people in a factory or six million people in one country, the system of rewards and punishments in force either from within or from without the group, will dictate its perpetuation, or its modification, regardless of how loud the outcries praising or condemning it (25).

As a result of the complexity of our new industrial society, has

the individual lost his sense of individuality in frustration or boredome? Have his thoughts, acts and ambitions been rendered null and void by group action and group thinking? Employment in some instances has become contingent upon membership in the right group (26).

The important fact is "that Labor has possessed the economic and political power necessary to enforce its demands; and it has used the power not merely to keep pace with the rising cost of living, but to exceed it by more than one third." (27). The present inflationary spiral is an important problem, and our people have a right to expect that facts will be presented to them truthfully. They have a right to expect, moreover, that the issues involved will be weighed in a reasonable manner by reasonable men with due consideration for our national necessities (27). Particularly is this important and applicable to the economics involved in solving the problems of health and welfare.

There is some evidence to support the belief that the progress of medical care programs in this country is similar to the pattern of events which has taken place in Great Britain. Labor unions, in the United States, have tried to organize complaints against both hospital and medical care insurance based on the assumption that the services provided are insufficient in relation to the cost of the premiums. If the voluntary plans are maneuvered, by such forces, into the vulnerable position of giving too much service for too little compensation, they will be bankrupt. Thus the door is opened to federal subsidy (28).

It is patently necessary to maintain the stability of private

general hospitals in this country. For, to place these institutions in the position, financially speaking, of needing federal support for their continued operation would invite federal control of these hospitals and pave the way to federal control of medicine. Consequently, if giving too much service at too little cost would threaten the stability of the voluntary prepayment hospitalization plans, then it would be wise to interrupt such policies.

Hospitals under contract with Blue Cross Corporations are legally bound to assume the cost of hospital care for Blue Cross subscribers for at least three months after funds are no longer available from these corporations (29). In time of crisis, these hospitals, having very little if any reserve funds, would be put to the necessity of obtaining assistance from outside sources, most likely from government. Viewing the possibilities in this manner, American and British history might come to run parallel. Therefore, we must proceed cautiously in establishing the extent and proper coverage of health insurance in the United States.

The Onset of Recession or Depression

There are predictions already on what is going to happen in the next depression, if and when it comes: "During the next depression it is likely that hospital admissions will remain high, and if the depression is less prolonged, the total income per patient per day will probably be less than the eight per cent decline of the 1929-33 period. Wages and salaries now represent a higher proportion of the total costs;

it is unlikely that expenditures for wages and salaries will decline more than five (5%) per cent. It will probably be necessary for the State to assist voluntary hospitals during a serious depression to meet operating expenses; and it is likely that the federal government will make funds available for hospital expansion and replacements as part of its public works program". (30).

There are possibilities of financial collapse that could bring the taxpayer in the United States into the hospital business as a full time partner. Such possibilities might be:

(1) Runaway inflation that would empty beds and send costs and accounts receivable soaring in spite of all the improved business methods.

(2) Another is war - involving the civilian population to an extent that would fill hospitals with casualties and make them depend on government payments.

(3) Another is continued drainage-off of doctors, nurses and other hospital personnel into the swelling Veterans Administration hospital system.

(4) Another, completely controlled economy that might result from a war or defense emergency and bring on compulsory health insurance, and

(5) The present danger that the public may get caught in the crossfire between embattled doctors and hospitals and call in the government to settle the dispute.

Hospitals will not close. Either they will make their own way

financially or they will ask for and get the kind of government aid that nobody really wants them to have (31).

The Government Record

On the basis of the following facts it is apparent that federally controlled compulsory prepaid medicine could put the capstone on a socialistic trend (9):

(1) Over 17 million people are receiving checks regularly from the Federal Government. Millions of others receive occasional checks for special purposes.

(2) The government has assumed responsibility for full employment.

(3) The solvency of banks and financial institutions is completely dependent on the monetary policies of the Federal Government.

(4) The housing industry is financed largely with government money.

(5) The government has promised to take care of the farmer.

(6) The nation's export trade is maintained largely by various governmental economic and military aid programs.

(7) The air transport industry is maintained by government subsidy.

(8) Control of electric power is partly in government hands. Control of atomic power is exclusively the responsibility of the government.

(9) Through TVA and similar government projects, whole areas of the nation are dependent on the government.

(10) The government fixes hours and conditions of employment and is intimately involved in wage bargaining.

(11) Old and disabled persons are dependent on the government.

(12) The Federal Government has impaired the sovereignty of the states by making them dependent on the federal treasury for grants in aid.

"It is not society's expectations of medicine that we fear and oppose. It is government control of the practice of medicine". (32). Experience has shown that once a country adopts socialized medicine, it has not repealed it. The reason for difficulty in obtaining repeal lies partly in the fact that the tremendous organization required to administer a plan of socialized medicine represents just so much political power; and party members influenced by their position are not going to vote themselves out of a job (33) (5) and (U.S. News and World Report - May 30, 1952).

Summary and Conclusions

Several of the sociologic and economic aspects of health and welfare programs have been presented.

A demand for better health at a reasonable cost has evolved from a series of technological advances which have not yet been completed. This demand does not appear to have been based, as it should be, upon a conviction that health is our most precious asset. Furthermore, a sociological pattern is being molded permanently by a series of group activities. The time has come for all groups to examine the facts and to consider the future.

In the first place, in considering health and welfare programs,

too much emphasis cannot be placed upon the necessity of understanding the individual. Basically, he desires to care for himself to be free to choose when, where and to whom he will go for advice and treatment. Yet this same individual seems to have lost the regard for these rights on the part of his fellow man. A few of such individuals do not desire to work for their right to be a responsible citizen. Some will abuse privileges; others do not desire them. The individual has begun to lose his individuality and is succumbing to group behavior patterns which may be based on political rather than humanitarian ideals.

It becomes evident that all interested groups have the common goal - good health. It also appears, from the pattern of national events, that federal control of medical care with its bureaucracy is not desired in the United States (13) (149).

Our people must further crystallize their opinion about how comprehensive the voluntary approach to medical care must be. Consideration must be given to the fact that we have a serious problem confronting us, partially as the result of the advances in social security. This problem is the economic status and the medical care of the older individual. In its solution, we can neither nourish bankruptcy nor exploit our youth.

We must also consider and accept the fact that it is neither necessary nor desirable that everyone be reached by the same kind of health program. Neither need the latter be comprehensive. Especially is this true in view of the facts that:

(1) We are probably in the "decline" period of population growth,

(2) Our labor force is limited, and

(3) The system of financing medical care is not a major factor in the health development of a nation. Other more important factors have been listed, and a solution to the problems inherent in these conditions must be investigated and secured.

If voluntary pre-payment health and welfare plans are to supplant government control of medical care, then private general-care hospitals must remain free of governmental control. A method therefore must be found to establish adequate hospital reserves to obviate the necessity of their seeking government aid in time of depressions or severe recession.

Medical care is a necessity, not a luxury, and people should consider it such. Medical care should not be furnished for all people by the government (145) any more than should food, clothing, or shelter. The procurement of all of these is individual, not a governmental responsibility.

CHAPTER II

AN APPLICATION OF EXPERIENCE IN FOREIGN COUNTRIES (Health and Welfare Plans)

There is much to be learned from an investigation of the medical care systems of foreign countries, especially those on the European continent. Particularly is this so in regard to the principles involved in their preventive and industrial medical programs.

A study of the pattern of medical care in England might be advantageous, especially in view of the fact that what has taken place in England could happen here. The culture of the United States is more like that of England than of any other country. In addition, there is essentially a common tongue.

The health and welfare systems of England and France will be discussed briefly in the belief that the pattern of progress in England has little that might be applied advantageously in the development of health maintenance programs in the United States. However, in France, important basic principles have developed which might be included in a satisfactory program of health and welfare benefits for the United States.

In a study (34) of medical care in Great Britain and the Scandinavian countries, emphasis has been placed on the similarity of the programs in England, Sweden, Norway and Denmark. All have the same goal - a nationwide system of comprehensive medical care for all of the people.

Generally, the people in these countries endorse not only the objectives but also the principles of national responsibility and of governmental action for its attainment.

In each country, medical care is a part of the social security program, linked to social insurance schemes assuring: the minimum protection against such hazards as temporary disability due to sickness, accident or maternity; long term disability and invalidism due to sickness or accident; death of the breadwinner; old age; and unemployment.

The building, and to a varying degree, the maintenance of all types of hospitals, outpatient departments and institutions for the custodial care of the sick are public responsibilities. The integrated hospital system (or what is considered to be the Central Hospital Plan in the United States) is stressed in their organization. In addition, all being tax supported, the hospitals are available to everyone regardless of income.

The health and welfare plans in these countries are administered by public agencies. Hospital professional services are performed, medically, only by specialists on a closed staff, the doctor receiving a fixed annual salary. The general practioner is responsible for office and home care and for certain preventive services, but not for services in public hospitals.

The medical care in England is financed totally through tax funds - 86 per cent from general taxes, 10 per cent from pay roll taxes, and 4 per cent from local property taxes. (U.S. News and World Report -

May 30, 1952, page 28).

In Sweden and Denmark more emphasis has been placed, in the past, on the organization of voluntary agencies - financed on a prepayment basis. The Swedish plan in fact includes a combination program of financing - voluntary and tax subsidized. One-third to one-fourth of the total operating funds of the voluntary agencies have come from taxes. However, general tax funds covered nine-tenths of the combined expenditures for the maintenance of tax supported services and for the subsidy furnished the voluntary sickness organizations. (Tax supported services include disability benefits and life insurance as well as health care for public cases.) It is reported that the sickness plans are soon to be supported solely through a compulsory program; this approach to be initiated some time in the early 1950's (34).

In Denmark, the law requires all to belong to voluntary agencies which are maintained on an individual prepayment basis, primarily. Tax subsidy is needed however - one-fifth originating from federal tax funds and about one-fiftieth from the local government (34).

Norway has a compulsory sickness insurance scheme covering about three-fourths of its people. This system is financed on a coordinated basis - six-tenths being individually prepaid insurance, less than one-seventh paid by employers, and about one-fourth by general tax funds - primarily national (34).

Medical Care in England

The power of the national government in England was accumulated

gradually. The British people at one time had a greater measure of personal freedom than those of any other nation save, perhaps, America. Thus they were not easily persuaded to submit to the assumption of great power by the national government. The process took many years but now the British government is practically omnipotent. Now every Briton is dependent on the continuance of the socialist program for his very existence (19).

British doctors know that socialization is basically a response to a very grave economic problem. Because they understand this, the large majority of the medical profession are trying to make the system work, even though frustration and disillusionment may be their personal lot. Nationalized medicine is working in Britain today because doctors take care of the sick regardless of other circumstances. There is almost universal agreement among British doctors that under the existing economic conditions, hospitals must be subsidized by the State, and that medical schools must have greatly increased support from public monies. But much anxiety is expressed because the government has taken over complete ownership of hospitals as its method of providing support. There is almost universal disagreement with the revolutionary method by which the Act was put into operation. The key word in the British physicians' consideration of the National Health Service Act is necessity (35) (Sept., 1950). (See below)

From a report "What British Doctors Think of Nationalized Medicine" by Stanley Dorst, M.D., Dean, College of Medicine, University of Cincinnati, and quoted by "Blue Cross Briefs", Hospital Care Corporation, Cincinnati, Ohio.

There are widely divergent opinions concerning the efficiency and general success of the National Service Act in England. Laymen of the upper social classes tend, in general, to favor the Act even though they recognize numerous disadvantages and deficiencies in the service. The general practicioners of medicine seem, as a rule, to be increasingly tolerant of the scheme. Specialists working as consultants with the service are, with exceptions, not overly pessimistic about its future, although they are highly critical of special flaws in its operation. Instances in which patients have been waiting a year for admission to hospitals for elective surgery are readily encountered. Dental and ophthalmologic services are lagging greatly. Hospital facilities are tremendously crowded. Acutely or severely ill patients are able to get rather prompt symptomatic care from the general practicioners. The scheme of specialist consultation appears well on paper, but wants in practical and efficient application. Medical teaching remains as the "status quo" and is apparently not geared to the medical needs of tomorrow. Curative medicine is given precedence, while preventive medicine is often neglected in medical instruction. The lot of the general practicioner, contrary to his hope, has not improved under the system. At the end of the first year, his status as an "honorable and renowned" citizen has lessened many times fold. It is practically impossible for anyone to get a thorough diagnostic work-up. There are no special diagnostic facilities available except in the teaching hospitals, and these are overtaxed at present (36).

The outlook for industrial and preventive medicine in England is not good. An investigation was undertaken by the Dale Committee to

study the status of industrial medicine and to make recommendations as to its relationship to the National Health Service. Industrial physicians are not included under this act and are paid by industry. In February 1951, this committee reported "No significant change in the existing status of Industrial Medicine." Thus, a postponement of a change for the better has discouraged planning or development of industrial health programs (37).

Medical care is provided essentially by four groups of doctors: specialists, private practicioners, public health physicians and industrial physicians. The National Health Service Act has tended to widen the breech between them. Another effect of the Act is that preventive medicine has suffered in England. As costs of the curative phases of medicine increase, and available funds do not, then monies available for the prevention of disease decrease. This includes funds for the public health medical departments and their employes who work within the limits of a budget (38).

What has been the experience with this type of medical care in England? From people in the United States who have studied the system, many of the reports are not good. England, after two years, has found that good medical care is impossible on anything like the amount of tax the people are able to pay. They are getting limited service, while in many instances the medical men are unable to live on their meager incomes (3).

Professional care is handicapped by overcrowding, and not a single new hospital has been built since the war (5). The average hospital stay per patient as listed for United States private hospitals (7.5

days) is to be compared to the 16 to 20 days' average stay for British hospitals (39).

Abuses of service are evident everywhere, and they must lead to more and more regulations, tighter enforcement, greater penalty for violations, further limitations of freedom and further deterioration of the quality of medicine (39).

Absenteeism is increasing rather than decreasing.....(The answer is found partly in the fact that the insurance allowance for sickness nearly equals the wages in certain low income groups). (39).

The cost of compulsory comprehensive prepaid medical care in England (when the scheme was enacted in 1946), was estimated to be 167 million pounds yearly. The first year's cost was 276 million pounds. The second year's cost was 450 million; and the third, 484 million pounds. Prepaid medical care is now the biggest single item in the civil budget, and is equal to one-fourth of Great Britain's entire allotment for national defense (5).

Conscientious doctors are being faced with an impossible job (Medical World). There is mounting discontent among the 19,000 family doctors who are engaged in providing health services partially because of pay, but also because the opportunity for improving the medical care of the people seems postponed indefinitely. Many doctors would prefer it to be a part pay system (co-insurance). This provision, British Medical Association reasons, would "induce a real sense of responsibility toward the Health Service Act on the part of those who use it". (5).

Abuses have occurred in the medical care system in England. Consequently,"for the first time in four years the people of Britain will have to pay directly for some health services." Included in the list are prescriptions, dental treatments, false teeth and wigs. This cut in the tax supported program of socialized medicine is a conservative move to save 56 million dollars a year. (During 1951, physicians handed out 140 million dollars worth of medicine without charge.) There will still be no direct fee for a physician's services, surgery, hospital care, or laboratory work (40).

"Who collects the payments?" The doctors themselves. They have to pay it out of their own pocket if it is not collected. This, of course, places a burden on the chronically ill, and may be the start of an economic barrier between the patient and the doctor (41).

In brief, the British Health Plan has two major deficiencies:

(a) Improvement in the quality of medical care is limited by isolation of the general practicioner, and

(b) Little attention to preventive medicine can be given by busy practicioners (42).

The Health and Welfare Program in France

The approach to the problems of medical care and welfare in France should be considered more in detail. (Reference is made to the Article on"France" published in the Ind. Med. and Surg. August 1951 by Leonard J. Goldwater M.D.)

In France, the present basic administrative organization of health

and welfare programs was established in 1946; however, the principle of factory inspection service dated back at least as far as 1874.

The system in France includes the following (43):

(1) Application of codes and regulations through a corps of factory inspectors, in which corps there are medical inspectors that have the right of entry and the right to examine workers in enterprises (essentially the development of preventive measures.)

(2) Each large city in France has a so-called "medico-social center" the like of which does not exist in the United States.

(3) All unemployed persons who seek unemployment insurance are sent to these centers for a medical examination and for a survey of physical capacity, which is used as a basis for employment in employment offices (handicapped included).

(4) The Ministry of Labor and Social Security administers the entire program which includes health examinations, sickness insurance, benefits for disablement, old age, death, unemployment, occupational injuries and illnesses, and family allowances.

(5) The program is financed through contributions amounting to 16% of wages - 10% employer and 6% employe donations.

(6) Family allowances, industrial compensation, and occupational disease benefits are distributed from a fund financed entirely by employer contributions.

(7) The sickness insurance program includes:

(a) Comprehensive prepaid insurance, which makes provision for

physicians' fees, drugs, hospitalization, and cash indemnities for disabilities.

(b) Doctors' fees are first paid entirely by the patient and then the patient is reimbursed by the fund for only 80% of the receipted bill.

(c) A fee schedule was worked out between medical societies and the administrative agency.

(d) Disability benefits begin on the fourth day and may last as long as six months, the upper limit of payment being one-half to two-thirds of the basic amount upon which specific contribution for financing the fund is calculated.

(e) Free choice of doctor.

(8) Industrial Medical Services:

(a) Every enterprise regardless of size must organize and provide industrial health service for employes. (Actually most of them have first aid stations.)

(b) These services are provided by industrial physicians whose work , "essentially" preventive, includes preplacement, periodic and return-to-work examinations, emergency and simple "on the job maintenance therapy" (Similar to U.S. Coverage), industrial hygiene and "process" changes, job transfer consultations, records and reports of occupational disease.

(c) The law establishes basic minimums with respect to space, equipment and personnel in the industrial program.

(d) In the compensation of doctors, special consideration is given to their training and experience.

(e) Graduate and post-graduate training in industrial medicine is offered in educational institutions.

(f) "Accepted" principles of industrial hygiene and occupational medicine are followed. These include referral of
(1) The seriously injured to the appropriate hospitals and
(2) the victims of non-occupational illness to private practicioner.

(g) Small plant programs are provided on a group basis, in a centrally located building, at the employer's expense in proportion to the number of his employes.

(h) A control doctor (independent of the industrial doctor) whose purpose is to determine when an employe is able to return to his job following an illness. This physician is employed by the government. (Certain disadvantages of the control doctor are referred to in Dr. Goldwater's article.)

Holland (43)

The most interesting features of the social insurance program in Holland are those related to sickness benefits and medical services.

Insurance is compulsory only for workers who earn less than about $1000 yearly (1950). Voluntary insurance is available for those who have higher incomes. Neither system is operated by the government.

A deficit in the voluntary system has been met by reserve funds in the compulsory system.

General practicioners are paid on a capitation basis, and hospital care is provided. Specialists are not provided for in the insurance system.

Only members of sick funds collect sick benefits amounting to 80% of their wages. Abuses of the scheme are said to be relatively infrequent, yet a "control doctor" system is employed.

Factory inspection is provided with authority of enforcement of the codes and regulations.

Discussion

A review of the health and welfare plans of certain European countries indicates that a national system of prepaid health insurance is the rule rather than the exception. The people in these countries have accepted the system, and evidently consider it to be a successful venture.

A movement is progressing in the United States in the same direction as that which has been followed in these countries. To date, the point has been reached here where employed individuals are "conditioned" to having some one else pay part of their medical bills. These employes evidently are not satisfied. There are indications that insurance coverage will tend to be more inclusive, and more costly to industry. Certain principles, now apparently accepted, cannot be abandoned without serious consequences.

In every foreign country studied, there have been adjustments in the system because of abuses, or controls have been established to prevent them. Likewise, the individual pays part of the bill directly and the remainder indirectly.

One cannot postulate the success or failure of any plan in the United States (compulsory or voluntary) by applying the successful principles in the health and welfare plans of foreign countries. This cannot be done because the medical care system in the United States differs from that of any other country.

However, knowing that our system is inadequate in certain respects, much can be learned from the principles represented in those of other countries, whether they be successful or unsuccessful. For instance, no totally comprehensive prepaid medical care system has been found to be successful, certainly not in the United States, where it has been tried to some extent. This is partially because of abuse and misuse.

To prevent abuse, some of the European countries have used a "control doctor" system; others have employed the principle of co-insurance, whereby the beneficiary pays a percentage of his medical bill directly.

It seems evident that completely prepaid medical care must be associated with some form of control. Controls result in loss of freedom either for the doctor or the patient, or both, and in deterioration of the quality of medical care. It would be far better to establish the principle of co-insurance, as a control in the United States, rather than further to limit professional freedom. By this ap-

proach, the control will rest in all individuals rather than in a chosen few.

Adequate medical care, as it is visualized in the United States, is very costly. In fact, the cost of general programs of medical care is so great that profit cannot be realized from them. As the medical care systems in foreign countries are reviewed, it is evident that none of them undertake to realize a profit.

Socialization in England has been a response to a very grave economic problem. At the end of World War II, private hospitals were either partially or totally destroyed, or in very poor condition; economically and structurally speaking. Renovation and rebuilding being necessary, in the case of hospitals which were devoid of reserve funds, it was agreed that hospitals should be subsidized by the state. As the needed support was provided, the government took over complete ownership of hospitals .... The United States government, too, assumes a position of priority in the case of bankruptcy of a hospital or health center that has received federal funds.

The principles set forth in the system in France have much to offer toward the solution of the problems of health and welfare programs in the United States, in the following respects:

Medical care and health are associated with the ability of the individual to produce. The cost of medical care is correlated with the individual's wages and therefore with the necessity for him to work and to be able to pay.

In a central agency, called the medico-social center, it is the responsibility of a physician to establish a "physical capacity profile"

for the individual based on the medical findings of physical examinations, which are completed specifically for this purpose. Employes are placed on a job, transferred, and returned to work as indicated by the profile.

In the French system, recognition is given to the value of a type of medical care based on accepted principles of preventive and industrial medicine and industrial hygiene; of co-insurance, and of the free choice of physician, for the family.

CHAPTER III

GOVERNMENT ACTIVITIES IN THE UNITED STATES

Government activities in the field of health maintenance have had a profound effect upon the developments in voluntary health coverage. For a number of years, those responsible for the administration of the federal government sought to establish a compulsory federally controlled, tax supported health insurance plan for the people of the United States. It is therefore understandable that the attempts of the government to improve medical care have moved in that direction.

During World War II, there was a need for maximum production. The satisfaction of health needs and the extension of social security benefits were designed to improve employe morale, to reduce labor turnover and to minimize absenteeism (44). It appears that these results were not accomplished (45) (46) (47).

At that time, the "fringe" adjustments were considered, in government wage stabilization policy, to be non-inflationary. The National War Labor Board gave the interpretation that health and welfare benefits were not wage increases, but were considered ordinary and necessary business expenses. Under the wartime corporation tax structure, excess profit taxes absorbed 80 per cent of the excess profit. Therefore insurance premiums could be regarded as costing only 20 percent of the sum actually paid for them (44). Under these circumstances,

it is understandable that industry agreed to subsidize part of the cost of the medical care which, in the past, had been an individual responsibility. Now the government is considering a proposal to tax these as income. Apparently an individual cannot expect to receive something for nothing even through governmental intervention (49).

In 1949, the federal government was obligated in part or in whole for the care of some 24 million citizens, of whom 19 million were veterans (50). At present, five large and over thirty smaller federal medical systems are operated in complete independence of each other (51). They compete for personnel that are in short supply. As a general rule they do not consider the facilities or needs of each other or of other agencies, and they do not participate in the development or operation of an overall plan.

The government has moved into uncalculated obligations without giving consideration to (1) ultimate costs, (2) the lack of professional help available to discharge them, or (3) the adverse effect upon the hospital system of the country (50) (51).

In the Veterans' Administration, where health and welfare costs have amounted to about 900 million dollars per year, there has been one administrative employe for each 97 of its beneficiaries. Projecting this to a proposed compulsory medical scheme, the administrative costs alone of federally controlled medicine might be as much as 4 billion dollars per year (52). This means that these administrative costs would be $25.00 per year for every person in the United States.

It has been the opinion of some of the representatives of the federal government that a national system of medical care, carried out

under social insurance and coordinated with old age and survivors' insurance, could adequately and economically meet the needs in this country (53).

The decision to be made is (1) whether the federal government should be permitted to continue its present policies toward the compulsory approach to health maintenance, or (2) whether limited federal assistance should be offered to the voluntary plans through a program that will not result in federal control.

Under the second plan, the government would provide aid to research, free medical care only to the indigent, and advice and assistance in preventive medicine, including school health programs (54). The compulsory federal plan (1), which has had strong support in government circles until recently, (Spring, 1953), should be considered in more detail.

Blanket approval of compulsory prepaid medical care has never been given by law. However, attempts have been made during the past 20 years to achieve federal control, by introducing laws in Congress, one by one, which would gradually accomplish the same thing.

Few of these bills (which lead directly or indirectly to federal control) have been defeated; most of them are still in Congressional committees. This creates a dangerous situation (55), since they can quickly be reconsidered.

This federal legislative activity has not only had its effects in the specific directions marked out, but also on the entire system of health maintenance as it has been developed in the United States over

the past twenty years. It can be divided roughly into four categories, which are related to:

(1) The Veterans' Administration

(2) Armed Forces and Military Dependents

(3) Policies established by the wage stabilization board, and

(4) The Federal Security Agency and the Hill-Burton Bill.

Federal, State and local government hospital and health expenditures amounted to 2.2 billion dollars in 1949, exclusive of the armed services. These government funds provided 71 per cent of all hospital beds (federal 13% - state 45% - local 13%). Twenty-five per cent of all patients admitted to hospitals were admitted to government institutions (predominantly patients with chronic disease) (56).

In fiscal 1952, Congress appropriated 2.5 billion dollars for health and welfare in the United States, excluding members of the armed forces. This was not sufficient to cover the costs, since requests for 511 million for Federal Security Administration and 30 million for the Veterans' Administration were yet to be approved (54)b. (This also does not include funds allocated to the Veterans' Administration for the construction of 30 new hospitals and 3 hospital additions, which would add about 20,000 beds to the 116,000 beds already in operation under the Veterans' Administration)(57).

The government will therefore probably pay over 3 billion dollars in fiscal 1952 for health and welfare in the United States, excluding armed service costs and Veterans' hospital construction.

Veterans' Medical Care

The government now is monetarily responsible for the medical care of more than 19 million veterans (50). If a veteran certifies that he is unable to pay for hospital or domiciliary care, the Veterans' Administration must admit him to one of their hospitals for service-connected or non-service-connected illness. The only restriction to total medical and surgical care for the veteran at government expense then is a restriction placed on the amount of money appropriated for the program by the United States Congress. One out of five veterans, when admitted to V.A. hospitals, have voluntary insurance (58). These veterans, if they have voluntary insurance, are apparently not sufficiently destitute to warrant care for non-service-connected illness at government expense.

Under Congressional authority the Veterans' Administration was permitted to give medical care for non-service-connected disability provided accomodations were available. The Hoover commission reported that the V.A. has taken advantage of this permission by building numerous hospitals solely for the care of such patients. Veterans with service-connected injuries, in the meantime, were moved to other hospitals (50).

During the period of July 1950 to June 1951, non-service-connected disability outnumbered service-connected disability about two to one, or approximately the current ratio, as follows (54c):

VA Illness	Percent Service-Connected	Percent Non-Service-Connected	Average days Hosp. stay 1950 Calendar	Cost per Patient Per day 1951	Percent Over 1950
All	36	64	60.8	$11.66	7.0
Tuberculosis	41.5	58.5	205.8	13.82	1.5
Psychoses	51	49	482.1	7.22	4.5
Other N.P.	24.5	75.5	60.3	7.22	4.5
General M&S	12.2	87.8	30.8	16.46	9.2

In 1950, the non-profit general and short term private hospital length of stay was 7.7 days (59). The average V.A. stay during this same year was 30.8 days for a similar type of service. As above, 87.8 percent of these cases were non-service-connected (54c). This prolonged hospital stay aggravates an artificial shortage of beds, which federal agencies evidently construe as justification for building more hospitals (51).

In April 1952, the V.A. informed Congress that 475 medical positions for which funds have been appropriated remain unfilled (60). At present, the V.A. has 116,000 beds. Construction grants have been allocated for 20,000 more beds (57), at a time when there are no professional personnel to man them.

The Veterans' Administration recently instituted a policy of accepting fewer non-service-connected cases; however, the number of medical personnel is not to be reduced, nor is the Veterans' Hospital construction to be interrupted. This action followed a reduction of 30 million in Congressional appropriation for the V.A. Even though it appears necessary that the V.A. must conserve its funds, 20 new hospitals are still to be activated before June 30th, 1953 (54d).

Although budget cuts have necessitated the closing of 2,800 beds in V.A. hospitals, statistics show that there is a steady increase in the numbers of patients. The latest summary records 99,019 patients in their hospitals as compared to 96,888 in June 1952 (54e).

It has been pointed out repeatedly in recent years that the federal government could not go on indefinitely providing free medical services for veterans whose ailments are in no way connected with military services. The time has now come to draw the line (61).

Military Needs - Armed Forces and Military Dependents

The difficulties encountered in the administration of community hospitals also will vary directly with the medical needs of the armed forces. Adequate medical services must be available for the Department of Defense. As more medical personnel take up service with the armed forces, fewer are available for the needs of the community. It is therefore important for the armed forces to conserve such personnel and to operate their units as efficiently as possible. According to available reports, this is not being accomplished (50).

The medical care of military dependents has presented certain problems also. Decreasing medical care has been available for dependents in military installations. The diminishing availability of medical care has been due to a decrease in the availability of professional personnel and facilities, associated with an increase in the numbers of military personnel and a need for a reserve for Korean casualties (54f).

An attempt has been made to solve this problem by introducing

Emergency Maternity and Infant Care Legislation in Congress. One such bill (covering military dependents) attempted to furnish services for maternity patients and also provide hospitalization for all dependents of enlisted men; estimates indicate that about 1.5 million people are involved, at a cost of 25 million dollars per year (54g).

Policies Established by the Wage Stabilization Board

In June 1951, the United States Wage Stabilization Board appointed a tripartite panel (representing labor, the public, and industry) which was to act as a guide to prevent inflationary economic trends; and to decide what "fringe" benefits may be allowed outside of official wage ceilings (54h) (152).

In August 1951, the opinion was announced that health, welfare, and pension benefits did not compensate for increases in the cost of living, since these benefits were not believed to add to the purchasing power of the workers and therefore were not inflationary (54i).

The industrial representatives on the tripartite panel have reported that the labor-public group on this Board supported a policy representing "no control whatsoever" when this principle was applied to satisfy labor demands, as a substitute for higher wages (54j).

In June 1952, the Wage Stabilization Board, as a directing policy, granted partial or complete payment of expense incurred by an employe or his dependents for medical care other than that covered by surgical and hospital expense insurance. Surgical, obstetrical, and hospital expenses other than private room were approved. The only brake then on

fringe benefits in this category was that they should not appear to the Board to be "unstabilizing" (54k). Agreements were to be reviewed by the Board, and if no notification to the contrary was received by the applicant within 30 days, the agreement was to go into effect.

By this decision, the Wage Stabilization Board practically automatically granted any anticipated increase in prepaid medical care coverage, and in fact removed it from limiting controls. This action would tend to support a trend toward complete medical care on a prepaid basis for the employe and his dependents at the expense of industry, regardless of its inflationary effect on the overall economy.

Provisions of the Federal Security Agency and the Hill-Burton Bill

A deficiency of nearly 900,000 hospital beds was reported to have existed before Hill-Burton funds became available for construction in the health maintenance field (State Analysis) (62). Shortages existed primarily in the rural areas.

The United States Congress in 1946 passed the Hill-Burton Act, the purpose of which was to offer federal assistance for construction of hospitals and health centers. This bill was approved and supported by the American Medical Association.

Originally, the federal government was to furnish one-third of the cost of the projects to the states, the remaining costs to be carried by the state or the community. In 1951 the federal share was 47.2 percent.

Representatives of the Surgeon General of the Public Health Service approve state applications for these federal loans (63).

Each state was required to designate an agency through which the plan might be administered. In all but six states, it was reported that the State Health Department is the designated agency. In addition, each state by law was required to establish an Advisory Council on Hospital Construction. To qualify for funds, the state must submit a revised plan for hospital construction to the Surgeon General each year for approval.

In 1949, this law was amended. Available funds were doubled to 150 million yearly, extended until July 1955 (63). (In 1952, Congress appropriated 182.5 million dollars for this fund. Part of the appropriation was for the liquidation of prior obligations.) (54b).

The new law provided a method of assisting projects which were begun outside of the Hill-Burton program, when construction had been stopped due to lack of funds. These were identified as "hardship cases".

No state could acquire more than two-thirds of the total cost from federal funds, but could get that much (63).

Up to July 1, 1951, the government had approved the construction of 1596 projects, 494 of which are completed; 990 are under construction. The total cost of these projects to the government is about 434 million dollars (50). Most of the new hospitals are being built in small towns and the smaller cities (63).

The basic purpose of the program is not to build more hospitals in the large metropolitan centers until the rural needs were more nearly

satisfied (62). Federal responsibilities are supposedly limited, and the law specifically forbids the federal government from operating any of the hospitals under the Hill-Burton program (63).

The advantages of having more hospital beds where they are needed are evident. The disadvantages of this and the overall program have not been clearly established. The Public Health Service is a branch of the Federal Security Agency. The Federal Security Agency is openly promoting complete compulsory prepaid medical care under government control. Hill-Burton grants are directly the responsibility of the Federal Security Administrator through the Public Health Service. This appears innocuous, until it is viewed in the light of the controls which the Federal Security Agency has over social security funds and the appropriations for crowded communities. In addition, if the recent bill (H.R. 7800) to extend social security had passed, it would have established a compulsory program of permanent and total disability benefits and cash sickness benefits for present social security beneficiaries. It also would have added farm owners, farm laborers, members of the armed forces, and certain groups of federal employes to the beneficiaries of the social security system. This huge program was to have been administered through the Federal Security Agency (54)l (54)m (156).

Another important and unemphasized provision of H.R. Bill 7800 is that it changed the method of financing a broad rehabilitation program for disabled persons administered by the Federal Security Agency, which is costing the United States about $21,500,000 a year. If H.R. 7800 had been enacted, the financing of the cost of this rehabilitation (now controlled by direct Congressional appropriation) would have been shifted

to the Social Security Trust Fund, and would no longer be subject to the control of the Congress (54)1.

To continue, in August 1951, coverage for 60 days of hospitalization for the aged entitled to social security benefits was requested by the Federal Security Agency. This was also to be administered by the federal government. Advice was to be accepted from the state Hill-Burton Federal Hospital Councils, but the latter would not have veto power. State health departments would be encouraged to handle the program; if not the hospital could deal directly with the FSA. Hospital admission to be certified by any physician (64).

When this law failed to pass, the Federal Security Agency reintroduced a similar bill in April 1952. An added feature this time was that either Blue Cross or other non-profit insurance coverage could be used, as the state desired, to cover the cost. No definite action has been taken on the new bill (54n).

And finally, under the guise of defense activity, if a community has been proclaimed a critical defense housing area by the President of the United States, and if because of the impact of this activity on the community, hospitals and other facilities are needed which the community is officially unable or unwilling to provide from its own or other possible resources, then applications for constructing such hospitals and health facilities may be received by the Federal Security Agencies' regional offices. Under this plan, the responsibility for administering such a program is shared by the Housing and Home Finance Administration and the Public Health Service. The Surgeon General of the United States Public Health Service is authorized by the Bill to

operate as well as build these health facilities, if the local community cannot or will not operate them. Where hospitals are needed, applications first must be made for Hill-Burton Construction Grants (54o). This therefore permits federal subsidization for urban hospital construction, whereas, under the Hill-Burton Act, these funds were to be used primarily for hospital construction in rural areas.

The government has no coordinated plan for operation for its medical facilities. Operations are duplicated in the Army, Navy, Air Force, Veterans' Administration and Public Health Service. The facilities of one agency are often crowded while those of a different branch, nearby, are half empty and their personnel correspondingly idle (50).

The pronounced disadvantage here is that this wasteful activity has created a very serious situation for the private general care hospital. A recent investigation by a lay group revealed that in two communities the administrative policy of the V.A. is exceedingly lax, and that the ability of patients to pay for care was completely ignored. Not only was the V.A. hospital excessively costly and non-productive in meeting the hospital needs of the community, but dangerous to the voluntary hospitals of that community. Private hospitals nearby cannot meet the higher salaries offered by the V.A. and will lose their employes to this system.

The Supreme Court has ruled that what the government shall subsidize, it shall control in the financial sense (48). The federal government thereby secures a priority position in the case of bankruptcy of a hospital that receives federal funds. Voluntary private

hospitals will probably have to request government subsidy in time of depression if and when it comes (30).

Revisions in the federal health programs apparently are needed (66) (67) (54p) (68) (10) (69) (70). The government's big job lies in such fields as statistical research, epidemic control, immunization, child hygiene, maternity care, etc. (10).

At present, appropriations for defense have priority, and any changes that might take place in the health maintenance field will depend upon their contribution to the defense activities. Therefore, the growth of health services that might be possible under more favorable conditions "will be slowed down considerably". (68).

As one of the revisions, the Hoover Commission favored a new Department of Health, which would have under its control the military and Veterans' hospitals. This transfer of military and V.A. hospitals was and is opposed by the American Medical Association. The Association believes economy could best be accomplished by coordination of the several hospital systems. It suggested joint use of available beds and joint planning in the field of hospital construction, and expressed the opinion that a central hospital board, with authority to adjust the hospital program to the needs of the services, will gain the end desired without a consolidation of professional personnel (66).

The United States Senate Committee on Government Operations has established a Federal Board of Hospitalization (established only in committee). The Board would be concerned with the need, location, and type of federal hospitals, and with the allocation of beds among the federal agencies in the interest of efficiency and economy. It would have

power only to advise the President and the agencies involved, and to report on progress to the Federal Congress. (It is interesting to note that a similar board functioned during World War II. It is reported that it was essentially unsuccessful and ineffective, because it was top heavy with government controlled members.) The A.M.A. believes that this board of ten members should be representative, equally, of the public and the government, and that representatives of large medical and hospital programs should be assigned as consultants and not as voting members. The Board should be allowed to promulgate rules for the V.A. in health matters affecting medical and hospitalization programs (54p).

At present, action involving V.A. matters must have approval of the interested committees in the House and Senate. This restriction may curtail the effectiveness of the activities of such a Board, if it is established.

As another revision, the Federal Bureau of the Budget urges " a complete and systematic review of all federal grants for promoting health," in the belief that piecemeal programs should be consolidated into broader programs, and state grants should be related to needs and resources. This belief is based on the principle that the objectives of the programs should be expressed in terms of results to be achieved rather than dollars to be spent (68).

However, the Chief of the Hospital Branch of its Budget Bureau recommends a single strong fully integrated military medical service, as a function of the Medical Policy Council of the Secretary of Defense.

This Council would no longer be advisory, but would (1) provide overall direction and control, (2) place responsibility centrally for program and construction planning, and (3) provide for unified operation of common service and activities (67).

Summary and Conclusions

Some of the government activities in the field of health maintenance and welfare benefits have been reviewed. A huge government bureaucracy exists in this field. Whether this bureaucracy has been established wisely and deliberately or on the basis of political expediency is certainly open to question. The situation, as it has developed, is not reassuring, and the recent Magnuson report (1952) has not cleared the air for concerted expedient action.

There is in existence federal administrative machinery which might be used to control all hospitals and hospitalization - the Federal Security Agency. A branch office is located in each state - The State Health Department. For, if Congress should decide that emergency conditions require greater authority in the hospitalization field, this could be accomplished by amending an existing accepted law - The Hill-Burton Construction Act. Hill-Burton grants are directly the responsibility of the Federal Security Agency through the Public Health Service.

The administrative machinery has been established and the law is on the record. All that is needed is public demand - on a basis of defense activity or economic catastrophe. It is therefore evident that

we may not have heard the last of compulsory federally controlled medical care. It is far from being a matter of the past; rather it should be considered to be a potentiality that will hang over the heads of the people of the United States for some time to come.

The private general care hospitals in the United States are being weakened by government action, and millions of people are direct wards of the government in health maintenance and welfare fields, through five ponderous and thirty smaller federal medical systems which are completely independent of each other. Control of the private general care hospital means control of the physician and compulsory medical care. Hospitals will not close; either they will make their own way financially or they will request and obtain government aid.

Private general care hospitals should remain in private hands. To see that they remain there is more and more becoming a direct responsibility of industry, since more and more hospital income is coming from industrially sponsored and approved health and welfare plans.

Similarly, the decisions of the Wage Stabilization Board directly effect the stability of the private general care hospital, as more and more inflationary decisions are made and approval is given by it for additional medical benefits for added thousands of the population. Industry, therefore, has an important interest in government activities which affect health maintenance and welfare benefits. Remedial measures are needed in the form of changes in the policies of the federal government. One needed revision is the removal by law of the priority position that the government has in the case of bankruptcy of hospitals that receive federal funds. And second in line is the limitation of funds for

the Veterans' Administration to those required for dealing with service-connected illnesses and disabilities.

If the stability of the private general care hospitals is not maintained, federal subsidy sooner or later may be necessary for them. Federal control of medicine will follow this subsidization unless positive steps are taken to prevent it. The only source of funds and of the organization required to take the needed steps is that of private industry, which must act in this regard in a wise manner, with understanding and forethought.

CHAPTER IV

THE CONTRIBUTION OF BLUE CROSS PLANS TOWARD THE SOLUTION OF HEALTH PROBLEMS

The Blue Cross Corporations are, as a group, among the most important developments in the accomplishment of a voluntary prepaid medical care system. The cost of hospitalization is covered by the Blue Cross Corporations for about 42½ (June 30, 1952) million people in the United States - one person in every four (72). An eventual membership of 140 million is by no means impossible. If all concerned understand and agree on the plan, there is no real reason why it cannot be achieved (73).

So far as can be determined at this time, the future plans in the Blue Cross System are indefinite. The prepayment goal for the Blue Cross System has been reported to be 100 million people. As has been mentioned, about 50 million people probably cannot or do not desire to be covered through voluntary prepayment insurance; these include government employes, indigents, those not interested in medical care, and those to whom the cost of medical care is not a factor (20). Nevertheless if the cost of medical care is to be spread over the community, these people so far as possible, should pay their share of the overall cost. (The size of the indigent and medically indigent population groups varies and cannot be determined accurately. Estimates of the

number of indigents in the United States, however, range from about 5 to 10 million people) (20) (73).

The establishment of proper objectives for the Blue Cross Corporations is not a simple matter. The problem involves not only the desired volume of coverage, but also an explanation as to approximately what the coverage should include.

THE VOLUME OF COVERAGE

The basic philosophies concerned and the understanding of service coverage, have changed as Blue Cross executives have accumulated more and more experience. Originally, Blue Cross was established to insure beneficiaries against the cost of hospitalization for acute illness. Coverage for chronic illness, as such, was not to be excluded, but was eventually to be dealt with in the same manner as acute illness (Sept. 1950) (148).

Today, Blue Cross coverage is not considered to be based on an insurance principle (148) (35) (Nov. 1951). It differs from other protection in that it offers the principle of service rather than that of insurance. For some people, and indemnity benefit covering only a part of the hospital cost is inadequate. The service principle was adopted because it was believed to be the only means of meeting the needs of the low income groups (19).

The Blue Cross Plans as yet have not met the needs of the lowest income groups (56) (OSMJ-page 744). (Decisions have to be made whether to include the "indigent" in the lowest income group, and whether the

hospital care of the indigent is to be solely a government function or a Blue Cross function at government expense.)

In some industries (those employing over 500 people, generally), one-half or even all of the cost of hospital care plans may be paid by the employer. Any cost remaining to be paid by the employe does not effect the "take-home" pay (45). Hospital care under such circumstances may cost some employes and their dependents nothing at all. Does this create a social inequity? If so, it could be alleviated through the organization of smaller industries into groups, in which, administratively and economically, prepaid hospital care might be made available to more people.

If an eventual membership of 140 million in Blue Cross is to be accomplished, such a coverage would include government employes, including members of the armed forces and veterans. This could mean that the government might be insured by a private insurer. There is some question as to whether this would be an advisable course to take.

It has been suggested that the Blue Cross and Blue Shield Plans and private carriers might enter into contracts with the federal government to service the claims of veterans with non-service connected disabilities and the dependents of servicemen. Presumably the insurer would investigate claims, pay the physician, the dentist, the hospital, the druggist, etc., report these amounts monthly or quarterly to the proper officials in Washington, and, after an audit of disbursements, the insurer would be reimbursed and paid some fee for his services, say 10 percent. Certainly the private firms, under these circumstances, could expect to have the insured (federal agency) dictate the terms of

the contract, the premium rates, and the claim adjustments. The private insurer might face the danger of absorption and control by the insured - (agency of the federal government) (74). The absroption of the Blue Cross Corporations by the federal government is a serious possibility, especially in time of recession and depression, when and if adequate hospital reserves and Blue Cross reserves are not available.

If the time comes that industry can no longer subsidize medical care because of its cost, then other sections of society, including those responsible for the care of the sick and injured, may also suddenly be financially incapacitated. In a society that is conditioned to having someone else pay the bills for medical care, there possibly might then arise the demand that the government assume the full control and the cost of medical care as one of its functions on a compulsory prepayment basis. If this happens, and if past experience continues, industry will still pay most of the bill, yet have no control. It therefore seems evident that if the principle of free enterprise is to continue as in the past, it will be necessary for industry to solve the problem of prepaid medical care.

Blue Cross coverage of government employes and indigents is a possibility, according to some Blue Cross executives. Steps have been taken to discuss such developments and to assume this burden on a cost-plus percentage basis (74). What can be done in the building of institutions (Hill Burton Survey and Construction Act), can also be done in arranging for voluntary insurance to prepay the cost of indigent care (75).

Prepayment of the cost of hospitalization for all servicemen and their dependents and other government personnel is possible; yet for some reason, deductions have never been authorized for servicemen and their families or for any federal personnel. The various health insurance plans would probably cooperate once Congress has voted to start such a program (54r).

The problem of the scope of application for Blue Cross is made even more difficult, if the responsibilities of the state and federal governments are properly observed. Indigents and people over 65 and their dependents are considered to be responsibilities of the states or of the federal government. Some states also are responsible for other groups of people by law. Therefore, if it is advisable for Blue Cross to assume part of the cost of the hospital care of the indigent on a cost plus basis, so might it be feasible for them to assume this cost for other groups having state aid, as, for example people over 65 and their dependents (54n). Obviously, part of the problem of the scope of the Blue Cross program relates to the inclusion or exclusion of the wholly indigent, the medically indigent, federal or state employes and their dependents, servicemen and their dependents, and veterans. If it is advisable to cover these groups, the cost of doing so must be determined and dealt with appropriately.

The prepayment of part of the costs of the medical care of 100 million people not covered by Blue Cross corporations should be given careful consideration. Some of the people in this group are in families

whose breadwinner is employed, yet the family is not self-supporting. Most of them are probably members of families whose breadwinner is not employed in an industry that offers Blue Cross coverage on a group basis. Many inhabitants of rural communities are also not covered. Since employes of smaller industries, as a rule, do not have the same opportunity to obtain "fringe" benefits as do the employes of large industries, a way might be found to group these employes and industries, in order that such advantages may be offered to them; similarly, prepaid health maintenance might be offered the farmer and his dependents through the national farm bureaus. Hospitalization costs for all the groups might be prepaid through a common non-profit organization such as Blue Cross.

Certainly, the possibility exists that most of our people can be provided with some form of group voluntary prepaid hospital care. This would be more readily feasible if it were administered on a "co-insurance" basis, through industry, where the benefits are based on employment. The facts, as are reported by the Blue Cross Plans, support this view and indicate that such an approach is economically feasible. For Blue Cross statistics show that if a large proportion of the members of a community is insured against the cost of hospital care (and the optimum would be everyone in the community), then hospital admissions in that community are reduced and hospital length of stay is shortened below average (72), the latter being the crux to the solvency of any voluntary prepaid hospital care plan.

In a city in southwestern Ohio, where there is private-general-care hospital of 166 beds which serves a community population of 40,000 or

more people, 75 percent of the people have been covered for the past six years by a Blue Cross Hospitalization Plan. This group has never used over 60 percent of the available bed space. The length of stay in the hospital for the group has consistently been about two days below the national average and among the lowest for the hospitals and populations served by the Blue Cross Corporations in that area. This evidently resulted from the fact that these people realized that their hospital bills would be paid and entered the hospital early, thereby expediting their recovery and shortening the average length of their hospital stay. This development could become a national pattern if most of the people in a community could be covered by service prepaid hospital care (72). (Many of the members in the Blue Cross Plan in that area were covered through a group policy in a large industry.)

CONCLUSIONS

Participation in the Blue Cross program of prepaid hospital care is advisable for all the people in the United States who might voluntarily desire to be covered in this manner. Particularly is the Blue Cross scheme applicable to the employes of industry and their dependents. An attempt should be made to offer Blue Cross protection to all employed people in groups, as economically as possible. Self-employed people and their dependents might also be reached in a similar manner. In addition, a considerable sector of the population of the United States is either directly an economic responsibility of some government agency

or is employed by it. Prepaid or postpaid Blue Cross coverage for this sector is not only possible, but desirable, provided government control of the insurer (Blue Cross) can be avoided.

The Scope of Individual Coverage

What should be included in voluntary prepaid Blue Cross coverage has not yet been determined. It appears that in the future Blue Cross may cover other phases of medical care than hospitalization. Consideration has been given to the prepayment of the cost of out-patient diagnostic services and home nursing care through Blue Cross Corporations.

An attempt is being made by Blue Cross officials to bring about a decrease in the length of hospital stay of Blue Cross members. To illustrate the necessity of giving attention to this problem, the experience in the Cincinnati area might be observed.

Cincinnati reports a shortage of 400 hospital beds. Similar shortages exist in most other southwestern Ohio cities. The reason for the shortage, as compared with an earlier period, is that more patients are being hospitalized longer. The results of a recent study of Blue Cross Hospital Care in-patient admissions are tabulated below.

Blue Cross In Patient Admissions (Cincinnati - Ohio Area)

	1948	1949	1950	1951
Average length of stay	7.11	7.43	7.61	7.67
Number of days of hospitalization per 1000 members	729	831	835	870

The average length of stay has increased by more than half a day during the last four years. The rate of admission is also climbing upward. The number of days of hospitalization per 1000 members increased from 729 in 1948 to 870 in 1951. This is an increase of 141 days of hospitalization per thousand persons.

The best means of relieving the hospital bed shortage is to reduce hospital stays whenever possible ..... and to treat at home those patients who do not require hospitalization (76). If, in concrete illustration of the point, the average length of stay in all hospitals (Blue Cross - Cincinnati Area) had been one-half day shorter in 1951, 63,800 fewer days of hospital care would have been required by Blue Cross members, at a net saving of $753,000. This saving alone would have obviated any need for Blue Cross to consider increasing membership fees (35) February 1952).

These findings might also be compared to the trends on a nationwide basis as reported in the "Five Year Trends-Hospital Utilization" (59): June 1951.... (Note comparison with government hospitals).

Average Length of Stay in Days

	1946	1947	1948	1949	1950
Non-profit general and special short term	8.8	8.1	8.5	8.0	7.7
Proprietary general and short term	6.6	6.4	5.8	5.6	5.6
Governmental General and Spec. short term	11.4	9.2	11.0	11.2	10.7

(As previously mentioned, the most favorable record - 2 days below the national average - was reported in the community in which 75 percent of the population was covered by Blue Cross Agency.) (72).

The trend toward more hospital bills on top of today's higher hospital charges will, if continued, bankrupt the voluntary health service prepayment plan (35) (January 1952).

The solvency of the voluntary prepayment plans such as those of the Blue Cross Corporations must be maintained. This should be done to insure the solvency of the private general-care hospital (preferably through adequate reserves), in order that government subsidization and/or control of these hospitals may be prevented.

In order that physicians might be informed, Blue Cross Hospital Care Cprporation in Cincinnati, Ohio, several years ago, instituted a policy of sending "Blue Cross Briefs", monthly, to physicians on the staffs of the member hospitals. It was believed that informed physicians would help curb certain abuses. The idea has been moderately successful, and other Blue Cross Corporations are instituting a similar policy. However, membership fees in the Blue Cross Plans may again have to be raised, since disadvantageous trends have not been halted or reversed (72).

Our people are not satisfied with the medical care coverage which they are now offered (17). In favor of expanding benefits under prepayment programs, Oseroff predicts that Blue Cross will include home nursing care, more outpatient diagnosis and treatment, and protection for those over 65. McNary believes that the only program the hospital can finance is one that includes all of the services required to restore the patient to health, and rules out a program with an arbitrary dollar limit. Hawley has contended that diagnostic services should be covered, and that prepayment plans must include these costs and those of catastro-

phic illness. Whittaker believes the following are needed: (1) Increased hospital and surgical-medical benefits to cover rising costs, (2) realistic appraisal of the individual burden, and (3) better understanding between insurance carriers and the doctors and hospitals that furnish the service financed by insurance funds (77)....

Home nursing care and outpatient diagnostic services on a prepaid co-insurance basis have much to offer. In the past 50 years, medical care has shifted from home to the hospital. This has developed partly because of the need for more accurate and complete diagnostic tests, many of which are too difficult and time-consuming to be within the facilities of a physician's office.

Hospitals furnish a more complete and a more scientific medical care, but not necessarily better medical care in the opinion of those who receive it. A general trend is developing in the United States toward the "central hospital plan" (78). Attempts are being made to reverse the trend of hospital care toward more care in the home. Prepaid outpatient diagnostic services and prepaid home nursing care might help to prevent unnecessary hospital medical care.

Blue Cross is considering including such costs of medical care within the scope of the Blue Cross system. It is believed that such a program would not be too difficult to administer (72).

The Blue Cross voluntary prepaid medical care system is abused when its members are admitted to the hospital for diagnostic services, when such admissions are forbidden in members' contracts. Under these circumstances, Blue Cross is paying for the increased cost of diagnostic services, plus room and board for the patient. If Blue Cross

would offer home nursing care and outpatient diagnostic services on a prepaid co-insurance basis, tremendous savings might be possible. There probably would be a decrease in the number of hospital admissions, which would obviate an alleged need for increased number of hospital beds. In time of financial crisis then, a burden could not be placed on Blue Cross Corporations by filling unoccupied hospital beds with chronic cases.

Prepaid outpatient diagnostic services would be difficult to control unless some positive restraint were placed on the program. This restraint might possibly be the principle of co-insurance, wherein the patient pays directly part of the cost of services. Such an approach has proven to be successful in several European countries, and it is one of the remedial measures suggested for the faltering socialized system of medicine in England.

Unfavorable Trends in the Blue Cross Plans

Certain unfavorable trends have developed in the Blue Cross System.

The greatest complaint against the Blue Cross Hospitalization Plan has been that it has overloaded the hospitals. Blame for this condition has been visited upon both patients and the doctors (28). In the cities where most of the workers are in UAW-CIO unions, the hospital insurance programs set up under collective bargaining contracts are creating demands by both workers and doctors for more hospital care than is available (79).

Such a development need not necessarily be viewed with alarm, for this demand, to a degree, is to be expected, if one of the four criteria

of the adequacy of a medical care plan is to be fulfilled, namely, that an adequate medical care program increases the utilization of medical services by the insured population (42). However, it does not follow, necessarily, as a result of increased utilization, that the cost and incidence of hospitalization should increase unreasonably and beyond economic limits.

The Blue Cross Plans may be paying for segments of medical care for which they need not and should not be responsible. In one Blue Cross Plan, if a member is admitted to an approved hospital for the treatment of tuberculosis, nervous or mental disease or disorder, chronic alcoholism or drug addiction, one admission of not more than 30 days will be covered during the duration of the subscriber's contract or renewal thereof, with a maximum allowance of $5.00 per day. (Full 70 day coverage is provided for such diseases and conditions in Member Hospitals). Some of these benefits in the Blue Cross Plans are not considered by some authorities to be insurable items and probably should not be included; rather are they governmental obligations (city, state, or federal), being accepted as such by the government agencies involved (56).

The cost of medical care is an insurable item, with the exception, perhaps, of that involved in illnesses which require prolonged treatment in chronic disease hospitals, such as tuberculosis and mental illness, or that arising out of disastrous epidemics and wars. This is now generally recognized (56 - Part I, Chapter VII, Page 101).

In contrast, however, one out of five veterans admitted to Veterans

Administration Hospitals carry voluntary insurance (not including direct payment accident and health policies) (58). Blue Cross cannot pay for the care of the predominantly non-service-connected disabilities of veterans in the Veterans Hospitals operated by the government and still remain solvent, under the present Blue Cross Plans. (In the last six months of 1951, $1,213,251 was collected for non-service-connected disability by the V.A.) (54g).

To gain volume of coverage, to gather in the preferable industrial group risks, and to satisfy the demands of labor unions and other labor groups, Blue Cross attempts to offer more benefits than do the private insurance carriers; the latter tend to employ the same tactics, and thus these impose upon each other pressure in the direction of progressively increasing benefits. Labor unions have complained vigorously that the services provided under insurance plans for both hospitalization and medical care are inadequate in relation to the amounts of the premiums. There is danger here that if the voluntary plans meet the demands of labor and thereby give too much service at too little cost, they will bankrupt themselves and thus open the door to federal subsidy (28). The keen competition among the carriers and among the plans is advantageous up to a point, but not to the extent of jeopardizing the solvency of the carriers or the fulfillment of their obligations. The level of premium rates should permit the rendering of necessary services (and also the building up of reserves for contingencies) to a large population in which will be included older people and the physically handicapped with their higher morbidity rates (Re: (56) Part I, Chapter IV, Page 66).

Private carriers admit that they do not desire to assume the responsibility for losses which are ill defined in relation to the situation or contingency against which insurance is provided (56) (Re: Part II, Page 118). It therefore appears that the private carriers will never cover the poorer risks of the non-industrial group at a price that these people can afford. On the other hand, Blue Cross policy indicates that their corporations can and will assume these risks (73), believing them to be part of an adequate prepayment medical care plan.

If keen competition cannot continue between Blue Cross and private insurance carriers because of the risk to the solvency of Blue Cross Corporations, and the private carriers will not assume the coverage for the poorer risks, it would appear that private carriers must withdraw from the prepayment hospitalization field; otherwise they must spread their coverage accordingly on a co-insurance basis.

Advantages of the Blue Cross Approach

Blue Cross offers service coverage; it is assuming a greater proportion of the risk that needs to be covered; and it is agreeing that more inclusive coverage is necessary. In addition (81), employes severing employment relations with an industrial concern having Blue Cross protection can continue it on a direct payment basis. The employe who transfers from one company to another or from one area to another can also transfer his coverage from one group to the other without great difficulty, and without a waiting period. In addition, the use of Blue Cross is simplified by the identification card. Similar benefits are

offered to the employes' dependents. In a period of crisis, recession or depression, these advantages may be decisive if maintaining a voluntary system is possible and desirable at that time.

Inter Plan Guarantee Fund

One of the greatest advantages of Blue Cross is that it is a single agency that can be expanded rapidly over the entire nation and nearby countries, under the control of an organization established on a firm foundation (82).

Blue Cross accumulated a million dollar guarantee fund after an alarming experience with a New Mexico plan. Dangerously near bankruptcy, this plan was rescued only after the national commission put in a new local staff and underwrote its activities (82).

The need for a guarantee fund in the Blue Cross was established as early as March 1, 1950 (83). "Such a fund would not be large enough for some years to rescue one of the large plans in case of financial difficulty. But the large plans generally have adequate resources to afford sufficient actuarial and accounting personnel, so that the need of a major rescue effort in an emergency situation should not arise. The large plans, however, should be willing to contribute the same percentage of their income to such a fund for the protection of the Blue Cross movement, and thus directly promote their own interests. Heretofore, it has been possible to reverse a bad financial trend in three to six months by simply increasing subscription fees. Competition and the law of diminishing returns may limit further increases in subscription

charges. Therefore, this fund should be large enough at the earliest possible date to carry a Blue Cross Plan through a complete reorganization, including revision of underwriting regulations, subscribers' rates and benefits and contractural agreements with participating hospitals."

"The monetary help guaranteed by such a fund seems to be of less importance than the building up of an organization within the Commission which will have power and authority to secure the necessary data and take the right steps to prevent financial difficulty". (84).

The Blue Cross Approval Program

Other valuable assets in Blue Cross are the standards and principles accepted in the Blue Cross Approval Program of the American Hospital Association (29). It took three years to obtain this approval.

(Under Section III of this approval program, definite standards are developed as follows:)

"A Plan shall maintain an adequate reserve for contingencies over and above all liabilities. A Plan's reserves (optimally yet minimally) shall be at least sufficient to meet hospital and operating expenses for a period of three months. A plan which does not meet this requirement, or which has not added at least 5 per cent of gross income to its contingency reserves during the preceding 12 month period, shall produce evidence satisfactory to the Blue Cross Commission and the Board of Trustees of the American Hospital Association that its financial policies are sound."

Member hospitals are obligated to furnish benefits to all subscribers enrolled at any given time. The agreement may be terminated on not less than 90 days' notice. Therefore in the Blue Cross Plans an attempt is being made to establish proper reserves; to make possible a principle of yearly audit and approval for each plan in the program; and to obligate the Member Hospitals to furnish benefits to all subscribers enrolled at any given time, and for 90 days after any contingency arises. Blue Cross therefore is subsidized locally by each Member Hospital.

Under Section IV, Principles Governing Relationship, (even though the corporations are not now operating on a cost basis,) Blue Cross includes in the accepted costs of service an allowance for depreciation of buildings and equipment and other contingencies as determined by mutual local agreement between hospitals and Blue Cross Plans. This, too, may be a decisive factor in perpetuating voluntary prepaid medical care in time of catastrophe.

The Principle of Co-Insurance in Blue Cross

Health maintenance, including all the types of medical, surgical and hospital care, remains a responsibility of the individual. Complete prepaid comprehensive medical care does not appear to be advisable for all the people in the United States. These facts, and those concerning the abuses of the prepaid medical care systems, have been discussed in other sections of this report. Certain disadvantageous trends concerning the factors involved in health maintenance have gradually developed and are continuing. Therefore a different approach to this complex problem

should be attempted - such as the principle of co-insurance.

Payment for the cost of hospitalization in Blue Cross might be combined with outpatient diagnostic services and home nursing care, all to be prepaid (including hospitalization) on a co-insurance basis. Such a packaged plan might be offered to large industries where the group risk is already organized. Blue Cross should aid in the formation of the small industrial health centers and agree to cover the smaller industries so grouped, in a similar manner at reduced overall cost, pursuant to volume coverage.

SUMMARY AND CONCLUSIONS

The activities of the Blue Cross Corporations have been summarized as they relate to the hidden responsibilities in the administration of health and welfare plans by industry.

An attempt has been made to establish what seems desirable to include in the prepaid medical care offered by the Blue Cross Corporations.

It is evident that a different approach to the problem of prepaid medical care should be attempted. Coverage should be more complete, and should include outpatient diagnostic services and home nursing care, on a prepayment co-insurance basis. Such a package plan should first be offered, without delay, to large industries where the group risk has already been organized, and in the near future to employes in the small industrial health centers, at reduced over-all cost.

Since employment is probably available for every individual, the preceding plan would satisfy the medical needs of the low income group,

especially if coverage on a prepayment basis is assumed through industry, where benefits are based on the individual's ability to produce.

Even though coverage should be more complete, Blue Cross should not assume the responsibilities which normally are those of government agencies, unless these agencies pay their proper share of the costs, and under circumstances which do not lead to federal control of medical practice or the programs of medical care.

In the field of health maintenance, the principle of continuity of private management should take precedence over a policy of competitive enterprise, under the present circumstances. In addition, prepaid health maintenance costs cannot be assumed on a profit basis. Therefore, if private insurance carriers continue to offer limited coverage on a profit basis, they should withdraw from the prepay hospitalization field in order to support the solvency of Blue Cross Plans, which must be done at all costs. Insurance companies have other more appropriate obligations to fulfill, as will be shown in the following paragraphs.

CHAPTER V

THE CONTRIBUTION OF PRIVATE INSURANCE COMPANIES TOWARD THE SOLUTION OF HEALTH PROBLEMS

The private insurance companies have assumed a major portion of the burden of supplying voluntary prepaid health maintenance service to the people of the United States. The accomplishments of these companies and others have been reported in the recent publication of the Health Insurance Council - "A Survey of Accident and Health Coverage in the United States." (85)

No group should be more completely convinced than the insurance companies that comprehensive prepaid medical care cannot be made available to all people because of the cost alone; that health maintenance is an individual problem and responsibility; that the point at which the insurance dollar and the public assistance dollar meet has to be carefully fixed, but both must be there. (80)

In the capitalistic democracy of the United States, industry is the main support, and directly or indirectly pays the bills. Commercial insurance companies are big industries. As such they have a most unique opportunity to develop a health program of prepaid medical care, health and welfare; but this does not mean that the program necessarily must be administered and controlled solely by private carriers.

The Role of Private Insurance

The policies of private insurance are based on recognition of the overall relationship between benefits and premiums, in awareness of the fact that the cost will be greater for an inherently sub-standard group than for an inherently super-standard group. This attitude differs from the philosophy of the governmental or social approach, in which benefits are related to needs, and costs to ability to pay. If the latter approach were used under highly competitive conditions, the solvency of the carrier could be jeopardized. There would tend to be an influx of sub-standard risks seeking a bargain, while better risks were turning elsewhere. The relationship between premiums and benefits lends stability to the plan and avoids the vicious spiral of changing premiums and benefits. (87)

Private insurance supplies a broad coverage, which is flexible and of the money-indemnity type. Such coverage has no geographical limit, nor is it limited to certain hospitals, doctors or groups. Insurance company personnel comprises persons trained to design sound schedules of benefits to fit individual circumstances, to spread risks, to underwrite and administer claims, and to manage finances. Through efficient utilization of specially trained personnel for the administration of many plans, the cost of handling is kept low. The administrative cost of handling small payments at frequent intervals has been shown to be out of proportion to the benefits received.

Private insurance carriers, together with Blue Cross and Blue Shield Plans, directly control a considerable portion of the prepaid medical care

dollar that is spent in the United States. In 1949, expenditures through medical care insurance were estimated to be about $755 million (hospital care - 530 million, physicians service - 225 million), or over 8 per cent of the 9 billion dollars spent for health services other than public health, research, and education (56). After three years of bargaining and arbitration, these amounts and percentages must now be considerably higher.

That insurance must be soundly conceived is accepted. Insurance companies have established principles upon which, apparently, they must operate, as follows:

(Murphy, Equitable Life Assurance Society - (56) - Part II, page 118.)

(1) The loss insured against should be of infrequent occurrence. There is no point in insuring a cost which is apt to fall regularly on the people who are to be insured, because such an item should be allowed for in any budget, and the cost of insurance administration, if it is to be insured, is simply added to the inevitable basic cost.

(2) The loss insured against should be of financial consequence. Here again must be considered the administrative costs of insurance and under what circumstances it is worth while to pay such administrative costs.

(3) The loss insured against must, for practical purposes, be beyond the control of the insured. This principle, if violated, is one of the pitfalls of compulsory insurance. It is obvious that the cost of insurance is indeterminate where the insurance

losses are not substantially involuntary.

(4) The loss must be of an amount which is definite when the contingency insured against happens. This is necessary for purposes of calculating premiums and for administration of claims.

Similarly, the principle of requiring the insured to be a co-insurer, or to bear some part of the loss, is a necessary one if over utilization or unnecessary utilization under comprehensive plans is to be controlled (88).

However, experience growing out of false relationships such as misunderstandings, fear, and an attitude of exploitation on the part of either the beneficiary, the insurance carrier, or the supplier of service, diminishes the essential value of the insurance plan as a social experiment or as a contribution to actuarial knowledge. Plans for providing medical care must be nurtured in an atmosphere of the mutual interests of all the parties concerned, or they cease to be essentially valid. In such a setting, the trend is inevitably toward more rather than less inclusiveness of those who stand in demonstrated need of services. An important safeguard lies in the provision that needy persons must be accompanied by a sufficient number of the others so that they are not in excessive proportions within the whole body of people admitted for benefits. These, too, are conceived to be true insurance principles (80).

Disadvantages in Private Insurance

Progress in the field of health insurance evidently is too slow (159).

Blunt statements have been made that certain risks which need to be assumed on a prepayment basis are being avoided (75), and that commercial insurance cannot be recommended to members of labor unions as being a satisfactory provision for prepaid medical care under collective bargaining contracts (17) (147).

It has been mentioned previously that commercial carriers, Blue Shield, and Blue Cross Corporations have been competing in an unhealthy manner for the preferred group risks and for volume coverage in the larger industries. This is occurring at the expense of accepted insurance principles which reportedly were to have been observed to the letter. For example, the private carriers were among the first to assume almost unlimited coverage for the chronic diseases which have long been an accepted responsibility of city, state, or federal governmental agencies. Their resources might and should have been used for other services.

Insurance companies have accumulated huge reserves which, of course, add to their stability. This is usually considered to be good business, but it may also constitute an unfavorable trend if the contribution to health maintenance is sacrificed to the continual accumulation of reserves.

Coverage by private insurance companies would be ideal if most of the people could be insured in this manner. Under such circumstances, any individual who is employed in any industry would obtain benefits at reduced cost by reason of their spread over the group. However, this is not now the situation, nor is it developing as the numbers increase. Inequities exist among people in the same income group. For example, smaller industries are not grouped, and therefore the proportions of the

cost of medical care which otherwise would be bourne by industry (and theoretically passed on to the entire community as part of the cost of the product), must be borne by the employes.

Private insurance does not satisfy certain obvious needs. Benefits from the larger private carriers are usually paid in industries which have limited their working forces to preferred risks, the poorer being weeded out by pre-employment examinations. The more these industries pay for health services, the more likely they are to be more and more selective in their choice of employes, if and when preferred risks become available. The remaining unemployed have been given the right (by industry) to demand consideration; they might get action through federal legislation. Obviously these risks need to be covered; they probably will not be if present policies continue.

Private carriers avoid insuring older people and individuals in the low income groups, in which the incidence of disease, both acute and chronic, is reported to be higher. Therefore, it appears that emphasis is being placed on fully assured profits rather than upon satisfying needs which, according to these same insurance companies, are becoming greater and greater.

At the same time, in dealing with the preferred group, most of the private carriers have sacrificed basic insurance principles by assuming the burden of costs for the medical care of diseases of prolonged and uncertain duration which are usually assumed by the government. It probably would have been much wiser if the insurance companies had insured more persons among the lower income and older groups, and had sharply limited

their liabilities within the field of the chronic diseases.

Among commercial carriers, most policies must be renewed annually, and the carrier reserves the right to refuse to renew the policy of any individual considered to be a poor risk. With a change of employment (group policies) (89) and on retirement, employes usually lose their insurance protection (30). Similarly, employes who have reached the age of 60 may lose part or all of their insurance benefits, for which, in many instances, they have paid for many years without return.

Four states have established non-occupational disability benefits, subsidized by industrial contributions, by statutory means. Non-occupational disability is within the proper field of private insurance and should be so covered. The state governments in these instances have assumed this function through default, and unless private insurance enters this field, it may be expected to develop further through governmental activity.

Most people want a health insurance plan which removes the economic hazard of non-surgical as well as surgical illnesses and chronic disease; and one which builds toward prepayment of integrated preventive and therapeutic programs. However, with few exceptions, little has been done about such major problems as heart disease, cancer, rheumatic fever, diabetes, tuberculosis, burns, osteomyelitis, severe fractures and other types of chronic or prolonged illnesses that can be more costly to the worker and his family than a hospital admission for a surgical procedure (17). Especially does this apply in insurance plans for smaller industries.

SUMMARY AND CONCLUSIONS

Since insurance companies comprise a large industry, any policies evolved in relation to programs of medical care that are applicable to industry as a whole should also be applied by private insurance companies. The commercial carriers appear to have been motivated primarily by a desire to limit their coverage to that which is safe economically and therefore profitable, and by a belief that the federal government is destined to take over all other responsibilities. Neither of these attitudes would seem to be wholly justified. Health maintenance being one of the most costly of human necessities, profit in its administration must be kept at a minimum. Breaking even or operating at a slight loss in the field of medical care insurance might not be disadvantageous to insurance carriers in the long run, if the private practice of medicine and the principle of private insurance in the field of medical care were salvaged thereby.

Prepayment insurance plans should give realistic appraisal to the individual burden. However, in many of the larger industries, the principle of absorbing all of the cost of health maintenance appears to be acceptable. In fact, this policy, more and more, is becoming an accepted principle at the bargaining table. On the other hand, private insurance is based, reportedly, on the plan of co-insurance - one in which the individual always pays a share of the cost of the item for which he receives a benefit.

As this difference is resolved, insurance carriers must approach the problem in a consistent manner, and not in a manner motivated solely by a

desire for profit. Emphasis might be shifted to a solution of the problems of health maintenance for the older aged and low income groups, and to employes outside of larger industries where the labor groups are not organized.

As the contribution of the private insurance companies toward the solution of health problems has been reviewed, it is evident that insurance companies and the other industries which they serve are obligated to solve the problems of prepaid health maintenance. Appropriate steps should be taken by private insurance carriers; the initiative in this field should not be forfeited to the federal government.

CHAPTER VI

ABUSES OF THE MEDICAL CARE SYSTEMS IN THE UNITED STATES

Once the decision has been made and accepted that compulsory prepaid federally controlled medical care is not desirable for the people of the United States, it follows naturally that, without delay, investigations must be made and conclusions drawn about the methods by which voluntary plans may be made more satisfactory. Particularly is this so in view of the fact that we have yet to offer such a program for the groups considered to have the greater health risks.

Reference has been made elsewhere to the fact that voluntary prepaid medical care, just short of being completely comprehensive, is very costly. Also that coverage for all for which it is indicated can hardly be accomplished so long as profit is associated with its administration. The abuses of compulsory systems in foreign countries have been reported.

The developments that have occurred and are occurring in the United States (as the various attempts to establish a satisfactory health maintenance system) have followed a course similar to that which developed in European countries, particularly in England. As we proceed in the United States, then, we should avoid the obvious mistakes made by others.

If the voluntary approach in medical care coverage is to be successful, an attempt must be made to eradicate the abuses of the systems that exist. There are abuses in the present voluntary prepay systems - gross, flagrant, unethical, dishonest, and very expensive abuses - by both

patients and doctors. Instances are being cited by the executives and the medical referees of Blue Cross (90) (13). Their records show that patients are hospitalized with diagnoses clearly intended to mask conditions which are not covered by the Blue Cross contract. Some doctors, singly or in groups, even threaten openly to sabotage the plan by unnecessary hospitalization of Blue Cross patients (90).

Experience with more than 500,000 hospitalized Blue Cross cases reveals that admittance to the hospitals has been requested by the physicians for minor ailments, conditions which may well have been cared for at home; and this has occurred in some instances, after the patient had informed the doctor that he was a Blue Cross member. In such cases, the question naturally arises, as to whether the patient would have been hospitalized at his own expense, if there had been no insurance. (91). There is that curious defect in public morality which makes it no crime to defraud an insurance company. Blue Cross is wholly at the mercy of hospitals and doctors, largely the latter, and must rely on them for protection against such abuses. Too many people (doctors included) labor under the erroneous impression that health insurance lowers the cost of medical care (92).

If any person or group is to be blamed more than others for abuses, it appears to be the practicioner of medicine. Some of his faults in this regard stem merely from human fallibilities of judgment and performance, but certain other members of the profession consider the practice of medicine to be a means of financial gain and that alone. Such persons should be denied membership in medical societies. (93) (154).

If doctors are to grasp the opportunity before them effectively, they must have clean hands. They must do more than talk about ethical standards. Physicians who are guilty of overcharging, neglecting or overtreating their patients must be dealt with. The highest possible professional standards must be maintained, for the few doctors who violate the ethical principles of their profession play into the hands of the bureaucrats by providing disgruntled patients who are willing to accept the hazards of socialized medicine (94).

Recently, there was a disclosure that some 200 doctors, mostly in the Los Angeles area, were cheating California Physicians Service out of more than a million dollars per year through;

(a) overuse of their services, and those of the clinical and X-ray laboratories,

(b) abuse of the Service, and

(c) outright fraud, which consisted of billing for services never performed.

A special committee, after studying this problem, hinted that it might be necessary to recommend an abandonment or at least a modification of medical care in the home and office, limiting the prepayment plan to hospitals only. Such a move would confirm the initial reservation a number of medical men had about extending health insurance - voluntary or not - to cover services performed outside of the hospitals. Home and office services, these men maintain, are bad insurance, for they invite overuse and abuse (95).

If there is one unpardonable sin in medicine, it is the failure

to consider, at all times and in all good conscience, what is best for the patient. There is too much meddlesome medicine and surgery that promises more to satisfy scientific interest and curiosity than it does to cure the patient (2). This, too, is abuse.

Bernard Shaw, a reckless critic of doctors, said, "Nothing is more dangerous than a poor doctor." Apart from sneers about ignorance and ability to kill rather than cure, it is noticeable how often greed is pilloried. As this is a recurrent and contemporary gibe, it behooves doctors to guard against even the appearance of this evil. Nothing will undermine the confidence of the public as much as the conviction that medical men are mercenary. Their services may be priceless, but patients have a right to fair terms, in keeping with public and professional standards of value (96).

In the transition from a practice which was largely an art to one increasingly a science, medicine has all but lost two priceless components of sound professional performance. The first of these is a sufficiency of time to listen to those who are sick and to deal with the presenting human problem as it requires, and the second is the personal concern of the physician for each individual patient (26) (164). Undoubtedly, there would be fewer hospital admissions if the doctor would just take the time to make a definite and proper diagnosis, especially in the realm of psychosomatic medicine, rather than, at the first suggestion of organic disease, to admit the patient to a hospital to receive numerous diagnostic services, many of which, when not prescribed by convention, have but negative value. Such procedures are

disastrously costly.

Whenever individual practicioners of medicine have received a fee for each service from an insurance fund for comprehensive and unrestricted medical care, the inordinate demands of the subscribers and, even more important, the financial rewards to the physicians for unlimited multiplication of their services, have created a combination of influences difficult, if not impossible, to control. The result of the inevitable multiplication of the professional services is progressive pyramiding of costs, superficial professional performance because of excessive volume, and the deterioration of the standards and benefits of medical practice (14).

Many of the ills of medicine are due to the indifference and irresponsibility of the medical profession. It is time to awaken and take stock of the situation. This awakening process is gradually coming about. But time is running out, and unless progress is more rapid, the solution will be taken out of the doctors' hands. The time is long past when physicians can confine their interests purely to scientific medicine. They must be interested in medical economics and social medicine and in the relation of the patient to his own environment (98) (97).

Abuses of medical care programs are not limited to the doctors alone. There is also the patient, who for instance, may know that a hospital admission is not necessary. This same patient may go from doctor to doctor until he achieves his purpose - admission to a hospital - which he thinks he is entitled to at no cost to himself. Doctors do not relish losing their patients in this manner. In this connection, however, it

is fair to point out that the doctor has some responsibility for explaining to his patients the effects of such behavior on their part, and for counseling them wisely in their own and the general interest.

Hospitals likewise must hold their charges to a true operative minimum, and no extra blanket charges in any category should be made in order to finance deficits or to furnish luxuries which do not contribute to the recovery of the patient (35)(June 1950).

A four point program for protection of voluntary prepayment plans has been listed: (35) (May 1950),

(1) Restrict hospital use to necessities.

(2) Eliminate luxuries in medical care.

(3) Avoid the performance of public service at the expense of the hospital (care of indigents, care in emergencies, training of doctors, nurses and technicians can and should be provided for, financially, otherwise. See below.)

(4) Establish a system of payment to hospitals that is fair to all concerned - Blue Cross, the hospital, the patient.

Payment for the actual cost of indigent care to the hospital is generally a function of government. When the latter, as is often true of local governments in particular, fail to assume such responsibility in

From a report "The President's Page" by Louis H. Skimming, M.D., Butler County Medical Bulletin, May, 1950, quoting Dr. Paul Hawley, distributed by Hospital Care Corporation, Cincinnati, Ohio as part of its "Blue Cross Briefs".

whole or part, other sources of funds must be found, the most available being corporations such as Blue Cross. In this way, units of government take advantage of medical care programs. It is just as important to see that government agencies assume their rightful share of hospital costs, as it is to influence people to assume their proper share in the maintenance of voluntary prepayment insurance.

SUMMARY AND CONCLUSIONS

It has been said that irresponsibility and lack of moral fiber appear to be becoming relatively more characteristic of our society as a whole. If this is true, the abuse of health and welfare plans is not surprising. Conversely, the prevalence of such abuse may well be one of the soundest evidences of the social and moral frailty of our people.

The groups which directly or indirectly are concerned with health maintenance and welfare benefits for the people of the United States are five in number: (1) the patients,(2) the physicians, (3) the hospital administrators, (4) government agencies responsible for the care of the indigent, and (5) administrators of the voluntary non-profit prepayment agencies and the private insurance carriers. It is interesting to note that all five groups have contributed to the abuse of health and welfare programs.

Abuse is practically impossible to control in an unrestricted comprehensive system of prepaid medical care. Therefore, such a system cannot be supported as being the solution to the perplexing problems of medical care which exist in the United States today. On the contrary,

an attempt must be made by all interested groups to eradicate the abuse of the present systems; especially since, as yet, the greater health risks do not have the adequate prepaid coverage so sorely needed.

As a source of abuse, the practicioners of medicine appear to have been most at fault. The physician must become interested in social and economic medicine (97) (98). Such interest may be expected to result in a change of attitude, but if the physician does not make the needed adjustments, he will continue to undermine the remaining confidence that the people have placed in him. This should not be permitted to happen, for the doctor, even now, is not in a favorable position. (154).

In the health and welfare field, the progress of events in the United States parallels the developments that occurred in European countries. As the practice of medicine became more and more completely controlled by government, the doctor, more than any other, lost his privileges. The medical practicioner in the United States, then, has the most to gain from a system of medical care which continues to maintain freedom for the individual.

Government agencies, in most instances, abuse present health and welfare programs by paying only a part of the cost of medical care for the indigent patient. Federal and state laws govern these payments, and, in general, insufficient funds have been made available. The laws should be amended to enable the agencies to pay the full cost of such care.

PART II

CHAPTER VII

VOLUNTARY PREPAID HEALTH PLANS

(General Applications)

In any medical care plan for the people of the United States, prepaid or otherwise, whether it be compulsory or voluntary, the responsibility for the health and medical care of the individual should remain directly with that individual. However, the future health, welfare and security of the people, collectively, will depend on the system of prepaid medical care that is established. Consequently, our leaders, and particularly our industrial leaders, whose direct concern is greatest, for reasons which have been examined in Part I, should assume the responsibility for effecting an efficient system, which will be administered outside of government and will be participated in voluntarily by the large proportion of the population.

There evidently is a real need for the financing of the cost of medical care on a prepaid basis. There is considerable difference of opinion about how extensive the coverage should be - both as to who should have this protection and what should be the scope of the medical care provided for in the prepaid scheme.

In Part I, the conclusion was arrived at that it is not desirable to have one single inclusive compulsory plan for every inhabitant of the United States, nor is it necessary or desirable to have prepaid

medical care of an all inclusive type. How inclusive then should this program be?

In the hospitalization field, executives of the Blue Cross Corporations neither consider nor desire their Blue Cross coverage of the cost of hospital care to be on an insurance basis. If the voluntary approach to prepaid care is to be a successful one, it must eventually include all the people (not covered by government agencies) who wish and need to be covered (148) (35). This means that such a plan should cover people who are classified as relatively poor risks and that service benefits be furnished on a non-profit basis rather than through profit-making activity with limited cash benefits (such as are provided in commercial insurance plans for employed people in groups).

At this time more than 86 million of our 155 million people receive varying amounts of medical and hospital care benefits from funds that are established on a voluntary prepaid basis. Of this group about 42½ million persons have prepaid hospitalization through Blue Cross Corporations.

At the end of 1950 the overall coverage on a voluntary basis for various forms of health maintenance was as follows (85):

	People
Hospital Expense Protection	77 million
Surgical Expense Protection	54½ million
Medical Expense Protection (Other than Surgery)	21½ million

A Social Security survey indicated that at the end of 1949 all or substantially all of the voluntary-prepayment organizations in the United

States that provide more or less comprehensive medical benefits were included in 184 plans with a membership only slightly in excess of 3 million people. About one-half of this membership was enrolled in industrial plans. (77).

The efficacy of voluntary prepayment plans is commonly measured by the proportion of the population protected and by the part of the family medical bill that is paid. Actually voluntary health insurance appears to have reached a far smaller proportion of self-supporting low income families than of those in the middle or somewhat above the middle income status (77) (56). Yet, families at lower income levels have greater need for medical care than do higher income groups. In addition, voluntary medical care insurance is most common among people who have easy access to group insurance. This may explain why twice as many people are covered in urban states as in rural. In any case, it seems necessary to find some means of including the large proportion of all employed persons in groups, in order that the voluntary approach to prepaid medical care coverage may include more people at less individual cost. Particularly is this applicable to the employes in small businesses. Over 99 per cent of the nation's employers maintain a roster of less than 500 people, and in these plants are about 60 per cent of the industrial workers (134). Few of these people have access to any planned health services, and many of them are not protected against the cost of medical care on a voluntary group basis.

Voluntary prepaid health maintenance plans now offer the following benefits:

(a) Hospitalization - on a limited cash benefit, or service basis. This includes care for the patient over 65 years of age, and for individuals admitted to special hospitals which are used primarily for the treatment of tuberculosis, nervous or mental diseases or disorders, chronic alcoholism, or drug addiction.

(b) Surgical care -

(c) Medical care - either in, or out of, the hospital, or both.

In the commercial group plans, insurance coverage is also offered for non-occupational disability (partial or total) on a temporary or permanent or dual basis. In some of the large industries, commercial insurance coverage is used frequently because private insurance companies offer several types of insurance at less overall cost and with less administrative overhead, when premiums are deducted from the employe's pay check at regular intervals.

It has been reported that some of the executives of Blue Cross Corporations, and others, are in favor of expanding the benefits in the voluntary prepayment programs to include home nursing, outpatient diagnostic services, and complete protection for catastrophic illness (Oseroff, McNary, and Hawley-(77).)

The growth of the voluntary prepayment medical care plans has been phenomenally rapid, yet it does not appear to have been rapid enough (159) (107). Suffice it to say, however, that whatever the future may be for health insurance, the quality of medical care must be maintained .... The quality of medical care depends in part on: (130)

(a) the method of organizing the medical resources;

(b) the continuity of care;

(c) standards of diagnoses and treatment;

(d) extent of preventive and rehabilitative care;

(e) the nature of the patient-physician relationship; and

(f) encouragement of education and research.

A medical care insurance plan should also be capable of meeting four criteria of adequacy. It should (1) reduce the financial burden of illness as much as possible by spreading the cost through prepayment; (2) increase the utilization of medical services by the insured population; (3) improve the scope and quality of medical care; and (4) promote prevention and early detection of disease. (Health Insurance Plan medical groups (New York) are learning that their professional and financial resources are being drained by preventable accidents and illnesses. In addition, they report that the average purchaser (of health insurance) has as yet exhibited little interest in the scope and quality of the medical services which the subscriber will receive under the insurance plan, or in the ability of the plan to provide preventive medical services and early detection of disease.) (42)

SUMMARY AND CONCLUSIONS

An attempt has been made to establish in general terms what an adequate medical care insurance plan should accomplish. Similarly, the qualities that are inherent in good medical care have been listed. With these criteria in mind, a voluntary prepaid medical care system in the United States might include the following:

(1) the principle that the establishment of the proper prepaid health

maintenance system is the responsibility and obligation of industry through a community approach;

(2) the principle that nearly every adult is employable regardless of age or physical condition (160) (161);

(3) the principle that the average family can finance and budget its ordinary medical expenses, if the proper priority is given to them, and therefore comprehensive medical care on a prepaid basis is not necessary;

(4) the general principle that the average family can also pay a portion of the cost of medical and hospital care that is now only partially prepaid, and consequently the principle of co-insurance for all phases of medical care coverage should be invoked for all beneficiaries, except those proved to be medically indigent;

(5) the cost of medical and hospital care for the indigent population must be borne in full by government agencies and should not be included in the voluntary prepayment scheme, except through an agency that operates without profit and on such a basis that the government does not maintain a position of priority in case of bankruptcy;

(6) health maintenance coverage on a prepaid co-insurance basis should include the cost of hospitalization, the cost of services rendered in the hospital by all physicians on a fee-for-service basis, home nursing care, outpatient diagnostic services, and (if and when possible) complete protection for catastrophic illness;

(7) the principles included in the Central Hospital Plan;

(8) a greater emphasis on preventive medicine;

(9) the utilization of the private general-care hospital, free of

government control; and

(10) more medical care in the home.

Admittedly, there would be extensive changes in the present system of coverage of medical care before such a scheme could be accomplished. However the above plan offers the following advantages:

(1) it establishes definite responsibilities;

(2) places the proper emphasis on principles that are necessary yet commonly ignored;

(3) gives proper recognition to the physician;

(4) establishes a plan of financing which is not federally controlled, yet is based on the ability to pay; and

(5) tends to discourage abuse.

CHAPTER VIII

MENTAL HEALTH

The importance of the problems of mental health is reflected in the many statistics throughout the United States, referable to this subject, particularly in regard to the admissions to and the length of stay in hospitals. However, aside from the problems of mental health in terms of hospital facilities, one-half to two-thirds of the calls made on physicians for medical care for any reason, especially those involving complaints of abnormality of the heart, head, or digestive tract, are emotional in origin. (99)

Further to describe the scope of the mental health problem in the community, in St. Paul (1951 report), for example, there were four times as many mental defectives known to local agencies as were being cared for by state institutions. There were twice as many patients in state institutions as those with diagnosed psychiatric disorders known to community agencies, but the case workers and correctional agencies reported 5,000 persons with symptoms of such disorders for whom there had been no psychiatric diagnosis (100).

In industry sixty to eighty per cent of all separations from the job are said to be due to social incompetence, only about twenty to forty percent being caused by technical incompetence (99).

One of the problems in relation to mental health derives from the

fact that private care for mental illness is beyond the reach of the workers in industry (101), and consequently the workers' dependents. There are instances, too, where qualified care for mental illness is not available.

Institutional care for mental illness is accepted to be the responsibility of government agencies at all levels. However, mental illness needing institutional care actually includes only a small part of the total problem to be solved, especially where a specific industry is involved.

A major weakness in the systems of health maintenance operating at this time has been the lack of knowledge and effort concerning the emotional factors in illness (102).

The majority of the people in the United States are either gainfully employed or are dependents of gainfully employed individuals. This means that the problem of mental health is related primarily to the employe and therefore to the industry in which he works. This is obviously reflected in the problems that are encountered on the job.

For example, the life of the worker outside of his employment situation may determine his success or failure at his work (103) (104). The employe's home life is reflected into industry, and family health problems may keep him off the job (105) (103) (106) (99). Absenteeism and accident proneness can reflect domestic conflict (99). Alcoholism, now considered an illness, is an admitted problem in some industries (103).

The problems of mental health in industry should be approached on an occupational basis. Occupational health aims at the promotion and

maintenance of the highest degree of physical, mental and social well-being of workers in all occupations (107). The newer approach calls for an understanding of the attitude of the workers for a knowledge of group morale and for psychological insight about top management itself (104) (141).

The idea that the problems of mental health might be solved on a community basis is relatively new. In fact, the whole approach to mental health is in its infancy. It has been suggested that part of the problem of mental health might be solved, if industry would assume the cost of a mental health program designed to assist the employe in this field. For example, such industrial programs have been described by private psychiatrists (103) (108) (109), labor groups (Union Health Center ILGWU) (101), and physicians in industrial medical departments (Eastman Kodak Company) (23),(Caterpillar Tractor Company)(110), and (Prudential Insurance Company) (134). These authors speak of the importance of the contribution made by a mental hygiene staff with specific responsibilities and duties. This staff, acting as an arm of the medical division in the examination of applicants for positions, conducts pre-employment psychological testing (141) and diagnostic interviews in order to appraise job applicants' abilities, skills, interests, and general adjustments (110) (142). In addition, a counseling program is designed to function as follows (110):

(1) to administer minor psychotherapy to employes with adjustment problems;

(2) to consult with supervisors in the handling of employe problems;

(3) to furnish psychological data with interpretations to the industrial physicians;

(4) to assist in arranging necessary leaves of absences, transfers, and other changes in employment through recommendations based on case findings;

(5) to assist employes and management in referrals of severe adjustment problems for appropriate professional handling (111);

(6) to consult with physicians and supervisors relative to rehabilitation and adjustment of employes who have undergone severe mental and emotional disturbances and have been declared capable of returning to work;

(7) to maintain case records of employe adjustment problems.

Psychotherapy can also help mentally ill people, who might otherwise accept or seek the status of the totally disabled, to understand how much more satisfactory it is from the standpoint of their health and character to continue to work, even part time, and receive income which they earn (102). Similarly, the use of the guided interview has been suggested, since the patient's opportunity to unburden himself, in many instances, will relieve his emotional conflict. In this way an accurate diagnosis might be made, and the patient may not need to be hospitalized for laboratory procedures which are costly and often of negative value only.

As has been mentioned, our aged population is a real health problem (21). The numbers of admissions of aged persons with senile psychoses or cerebral arteriosclerosis threaten to grow because of the increasing numbers of older persons in the community. This problem may be held in

check if comprehensive programs for the aged are developed, which will contribute to their general adjustment (30). One of the pressing needs for the handling of the elderly group in industry is to provide a program which allows for early detection of disease of all types and for the institution of remedial measures. Some twenty-five million elderly people are suffering from some phase of chronic illness; seven million of them are disabled (112). Inasmuch as industry is the main support of our country and will have to pay the bills, it is logical that industry should make a concentrated effort to handle this problem (112).

For these and other reasons, mental hygiene for older workers may eventually be a major part of the program of occupational medical departments. Some industries have already taken action to help solve the problems of their older employes (113) (114). Mental health means money in the pocket of industry (99) (102).

CHAPTER IX

THE PRESENT AND FUTURE HIDDEN RESPONSIBILITIES OF INDUSTRY IN THE ADMINISTRATION OF HEALTH AND WELFARE PLANS

General Scope of the Problem

The revisions that appear to be necessary in the health maintenance system in the United States cannot be accomplished in a short period of time, and probably not in this generation. In this adjustment process, the desirable advances of the past should be maintained and the disadvantageous trends should be ferreted out, properly exposed, and avoided. As a basic principle, compulsory prepaid federally controlled health maintenance is considered to be undesirable for the people of the United States.

Industry in one or another of its aspects includes nearly all the people. The numbers of people in a specific industrial organization only delineate the size of the industry. As progress has been made in the health maintenance field, the emphasis has been shifted toward the solution of the problems in industries where large groups of people can be served easily and economically. Much has been accomplished in this manner, but an unhealthy situation has developed through neglect of the people who do not have access to group advantages, i.e. the people employed in small industries, farm groups, and the self-employed, who together comprise the majority of our working population.

An individual should produce for his right to live, rather than accept a dole at the expense of the mentally and physically healthy, who through effort and intellect are able to be self-sufficient. Thus the individual becomes the important element in society, and his good health becomes an important asset to himself and to society. If the people in the United States are to approach the problem of health and welfare in a consistent manner, then means should be found for offering health maintenance to the employes of small businesses as economically and as equitably as it is offered to workers in larger industries.

The health of an individual must be maintained so that he can work for his and his dependents' right to exist in a free society, and if health problems are to be solved, all employers must assume certain responsibilities for the maintenance of health in that individual even though he may not be an employe. For example, if an individual's health cannot be maintained fully, then what is left should be salvaged. The policies of industry must be altered to include the principle that jobs are to be available for all people that desire to work, even those who have limited physical potentialities; if this is done, the handicapped individual will be placed on a job which can be done within the limitations of his disability. Such a plan can only be accomplished through community cooperation. It cannot be done by big businesses alone, since their working forces can only assume their share of the burden under competitive conditions. The goal then is health maintenance for production (115). Health becomes an individual

responsibility but health maintenance an industrial obligation (115). If industry does not assume this obligation, the government apparently will.

To offer such a solution is simple; to accomplish it is difficult and costly. Especially is this true when for twenty years we have deviated from the above principles. The changes in health and welfare programs that appear to be necessary will not materialize until responsible management in both large and small industries are convinced that a new approach is feasible and worthy of support. This paper has been prepared primarily in an attempt to convince this group that a new approach is feasible.

The problems of health maintenance are local to the community. Too much money and too much effort are being expended in the establishment and administration of national bureaus and agencies. This is true especially of the private organizations, in which more emphasis is placed on maintaining the administrative structure of the unit than on solving the problems of the sick. These agencies are large and cumbersome, and as such would not be necessary if the responsibility of health maintenance were to be assumed locally. Management should funnel its funds toward solving the problems within the community; administrative and technical assistance should be evolved from the experience of industry within that community.

Management should also realize, regardless of the tangent upon which they approach the health maintenance problem, that the core of the matter lies in the practice of medicine. The physician and more specifi-

cally, the physician in industry, is more and more becoming the focal point at which many of the problems of health maintenance can be solved.

It behooves management then to accept the physician into industry for the responsible position that he must hold (116) (165). The physician in industry must be recognized, and given (1) authority commensurate with his responsibilities, (2) appropriate placement in the industrial organization, and (3) the opportunity to participate in the decisions of top management as these relate to the problems of medical care and health in the community, and to the promotion of industrial health.

The intricate problems within the industrial environment are foreign to most physicians. Therefore, for the benefit of industry itself, management should place as much emphasis on the proper training of the physician in occupational medicine (98) (115) as on the training of other executive personnel. This requires funds, training facilities inside and outside of industry, and the coordination of these into effectual educational facilities (98). Such facilities are available to a limited extent and can be increased to the point of adequacy when professional interest in the problem is brought to the proper level.

The physician trained in occupational medicine can become one of the most important of medical specialists. The point is that he must be recognized as such by industry, primarily. Similar recognition from his colleagues will be forthcoming when the responsibility and authority of the physician in industry are recognized by the company that employs him.

Post graduate training in occupational medicine cannot be accomplished by the doctor of medicine without further personal sacrifice and effort. Therefore, once trained he must be paid adequately. The income of professional men in industry should be commensurate with their responsibilities to society and to industry, as well as with their proficiency in training and experience.

Adequate compensation and recognition within the industrial community are not the only requirements that must be fulfilled if the doctor is to become interested in occupational medicine. Medically, the United States is in an era of specialization. Qualified doctors may not choose occupational medicine as a specialty unless it comes to be recognized as such. Industry, indirectly then, has an interest in seeing that such recognition is forthcoming.

Other administrative and management responsibilities in the problem of health maintenance are summarized under the following headings:

(1) The need to observe certain overall principles.

(2) National and state legislation.

(3) Organization of an industrial medical department.

(4) An application of the proposed principles to the administration within the company.

(5) Community needs.

(6) The properly integrated health maintenance system. (Separate section)

The Need to Observe Certain Overall Principles

Specifically, industry needs to accept, develop, and apply a more definite program of health maintenance. This program should be based on the following principles:

(1) the maintenance of good health in the employed population is an industrial obligation;

(2) such maintenance should be accepted as a direct responsibility of industry, and not as an indirect one through government;

(3) the job cannot be done unless more funds are allocated by industry for training and research in the health maintenance field;

(4) funds made available by industry for this purpose should be used to solve the health maintenance problems of the community and should not necessarily be allocated only to agencies and bureaus which are nationally organized and have top-heavy administrative costs;

(5) the overall needs to be satisfied are those of individuals and not of agencies or labor unions;

(6) more emphasis should be placed on the prevention of functional and organic disease, and less on programs which relate only primarily to treatment of illnesses and injuries;

(7) industrial, as well as the sociologic, ills and diseases are often secondary to deviations of mental attitude, which means that prompt attention should be given to mental health within the industry and the community, and therefore financial support should be provided for these activities;

(8) employment is probably available for all breadwinners of all ages (160) (161), regardless of their mental and physical condition, unless they are hopelessly, totally and permanently disabled.

Industrial Responsibilities in Relation to National and State Legislation

A concerted effort must be put forth by all industry to effect a change in the trend toward control of medicine by the federal government. Such a change can only result (1) from the passage of new laws which might effectively alter the trends, or (2) by defeating laws which directly or indirectly tend toward governmental domination of medical practice. Such efforts may be illustrated by the following paragraphs.

(1) Government agencies have attempted to increase their responsibilities in the field of medical care by sponsoring legislation which will provide federal control of the prepayment of the costs of medical care for increasing numbers of people in groups. This trend should be interrupted.

(2) A serious situation has developed for private general care hospitals as a result of the governmental policy that total medical care of the veteran is being paid for at government expense. Private hospitals cannot possibly meet the competition created by unlimited federal facilities and funds for caring for veterans' non-service connected disabilities. The simplest way to inhibit this competition is to limit

the funds appropriated for the Veterans Administration, since, if this is not done, the cost of hospitalization in private hospitals may increase to the point that prepayment through voluntary agencies will be impossible.

(3) Industry similarly has a direct interest in seeing that medical care for members of the armed services is furnished efficiently by the government.

(4) Care must be taken that industrial contributions will not have been used to subsidize community hospital bed units which eventually become total responsibilities of the federal government (Hill Burton Hospitals). At present the federal government, through a decision of the United States Supreme Court, occupies a position of priority in the case of bankruptcy of hospitals and health centers which have received federal funds. Industry should insist that such priority be abolished through process of law.

(5) State and local government agencies are properly responsible for the medical care of certain groups of people. Most of these agencies assume a privileged position when paying only a percentage or a flat fee for the medical and hospital care of these people in private institutions. Industry should support the policy that government agencies be required to pay the full cost of medical care for these people. This can only be accomplished by altering present state laws.

(6) Handicapped and disabled people are not being employed by industries in some areas. When industries do employ such persons, they must often assume full economic responsibility for (a) the aggravation

of a previously existing handicap or disability, or (b) for permanent and total disability based in part upon an abnormality that existed at the time the individual was hired. State laws must adjust this inequity, possibly through inclusive "second injury laws". Otherwise disabled and handicapped individuals may not be employed.

(7) And finally, insurance against non-occupational disability is within the province of private insurance carriers. Industries should not let this responsibility be assumed and controlled by state agencies through law and default. Since health maintenance now includes non-occupational disability benefits, industry should cover such contingencies through company-employe co-insurance in private insurance carriers.

Organization of an Industrial Medical Department

The medical department in industry should be organized solely on the principle that health will be maintained for production. It is known that the properly functioning industrial medical department saves money for industry, as it assists in maintaining the health of employes (111). The truth of this principle becomes more evident as fringe benefits increase.

Employers generally have been obligated to furnish medical care in relation to occupational injury and disease. Having accepted this obligation, industry now rightfully assumes a responsibility in other medical fields. If progress is to develop in the right direction, the emphasis must be placed first upon the prevention of occupational and non-occupational disease and injury. The expense and liability of other phases of

preventive and curative medicine might then logically follow.

To be more specific, each employe should receive a preplacement physical appraisal. The potential employe is to be considered in his entirety, and therefore some examination into his mental and emotional qualities is essential, whether this is done simply and non-technically or by trained professional personnel. Following these measures, the employe should be placed, so far as possible, in a job that can be done safely and satisfactorily by him. Otherwise he may be put in a job that would be injurious to his physical well-being, ill-adapted to his interest and skill, and unsatisfactory alike to himself and his employer.

Proper job placement also involves the availability of precise knowledge concerning the characteristics of the environment in which the employe is to work. Once the employe is placed on a job, information about him in his working environment must continue to be obtained, since his reaction thereto is concerned with his good health. The adequacy of the hygienic control of the environment therefore is a matter of deep concern to the medical department, and those whose function it is to exercise such control are best located within the medical organization (115).

When the employe is diseased or injured on the job, he should be given the best of therapy, which more than likely will be at the hands of private practitioners of medicine outside the industry. From the economic viewpoint, the return of the employe to his job is of paramount importance to him and to his employer, and therefore the best of medical or surgical care is the most advantageous. Rehabilitation measures and re-

peated surveys of physical capacity may be necessary in order to place an individual workman on the proper job following an illness, injury or convalescence. Meanwhile, investigations should have been made to determine how such occupational disease or injury can be prevented in the future, and remedial measures will have been initiated.

The employe's return to work or his transfer to another job (for medical reasons) will depend on his capacity to do the job and on that alone. Perhaps he should be placed at another work station temporarily until he is able to accomplish what is expected of him at his regular position. The determination of his capacity therefore becomes an integral part of the performance of the medical department.

In summary, the medical department in industry should be organized to assist in the practice of preventive medicine, and should include: -

(a) A properly trained staff.

(b) A policy of employe placement based on,

  (1) functional capacity (which in addition to physical qualifications might include dental conditions, the status of the special senses and mental health;)

  (2) job analysis, job specifications, chemical and physical environmental control, and safety procedures.

(c) Proper treatment of disabilities, including,

  (1) an attempt to maintain the employe on the job;

  (2) referral of in-plant disease and injury, when possible;

  (3) rehabilitation of the employe (114) (158); and

  (4) return to work and special job transfers based on

available medical evidence concerning the man's physical and mental ability to do a job.

(d) Environmental surveys to maintain a satisfactory environment in the industry and its surroundings, including investigations of the extent of the pollution of air and water (118) (119) (165).

(e) Application of the principle of functional capacity to the problems of the handicapped and older aged employe.

(Health maintenance in industry may, under certain circumstances, include (1) additional emphasis on mental health, through the applications of psychiatry, psychology and social service; (2) home nursing care; or (3) in-plant dental service.)

Applying Accepted Principles to Administrative Policies in the Company

It will not be a simple matter to convince the mangement of many companies that industry must assume the initiative in the field of health maintenance. However, once the initiative has been accepted, and even as it is being accepted, the idea bears fruit in the discovery that the responsibility no longer is limited to a single group of employes. The obligation extends beyond the industrial organization into the community. In other words, the plan of an industry and of industry collectively should be included in community efforts to solve community problems and to satisfy community health maintenance needs. As mentioned, medical care is not the only need to be satisfied. The larger the industry, the

greater the obligation, because as an industry grows, it assumes responsibilities for more and more people. Indirectly, and perhaps unwittingly, management accepted such a responsibility when it agreed, during and following World War II, to subsidize part or all of the health maintenance care of its employes and their dependents.

By the coordination of community effort then is meant several things. It includes the understanding that hospitals and other medical care institutions are themselves akin to industries. That, by and large, these institutions are not operated efficiently, since they supply medical care which is too costly. That, for any plan to be totally successful, these medical care organizations will have to be as efficient as they can be made to be. This means that a coordinated community effort will include an interest on the part of industry in seeing that satisfactory business practices be developed and employed by these medical organizations. This would indicate a need for action outside of a company concerned, for few industries supply complete health maintenance care through company-operated and administered health maintenance units.

The initiative must be assumed promptly by large industrial organizations, which will accept the need:

(1) To sell the idea of community responsibility for health maintenance to labor groups and to other people in the community, and specifically to the management of smaller industries;

(2) Of accepting and placing on a job, the handicapped and/or partially disabled; this, too, to be accomplished on a community basis and not to be the obligation of individual industries;

(3) Of altering the methods and policies of production, in part, in

order to (a) properly place and (b) maintain the health of the disabled, handicapped, and aged employes who can produce;

(4) To support the establishment of small industry health centers which will satisfy community needs in addition to industrial responsibilities;

(5) To employ and train personnel to administer the program.

Community Needs

Solving the health maintenance needs of an industrial community is largely the obligation of industry. This does not mean that industry, through its medical organization, should engage in the private practice of medicine with its emphasis on the therapeutic field of medicine. Diseases and illnesses are best prevented.

The health maintenance facilities in the United States are inefficient, unsatisfactory for some of the people, and too expensive for many others. The problems and needs in this field can be solved and satisfied through community effort, and should not require governmental intervention, although the participation of local government may be advantageous.

The specific needs in the community are those (1) of the individual; (2) its industries; (3) the health maintenance systems; (4) future employes; and (5) the physicians.

The emphasis within the community should be placed on the necessity and the right of the individual to work to produce so as to earn his share (and those of his dependents) of an improved standard of living and a form of

security. A job is probably available for every one regardless of his mental or physical condition unless he be hopelessly, totally and permanently disabled. To create these jobs, and to see that they are available for the people in the community who desire to work, is an industrial responsibility to be accepted and coordinated through cooperative planning.

The problems of unemployment of the handicapped, partially disabled, and older aged employes must be recognized and measures attempted to solve them. The employment of these people may be the simplest solution.

Industry and the community should also recognize that disabled and handicapped people can reproduce as well as produce; that their progeny will be future employes. Perhaps for this reason alone, concentrated emphasis on their problems may be advisable, since often the standard of living in these families is low and their children consequently are neglected. Industry plans for future markets and production, why not for future employes?

Automatically then, health as well as education, in the schools, become matters of concern to industrial management. In view of the fact that all of tomorrow's employes will come from the group of students attending school today, educational and health needs should be provided for them. No better investment for the future might be made. As a general rule, school health facilities are being inefficiently administered because therapeutic, diagnostic, and preventive medical measures are not coordinated. Industry could lead the way by giving concerted effort and interest to solving the health problems of children of school age. Industry need not pay the bill but only recognize that the needs of these - their future employes - do exist and do something about them.

It is particularly important to make a positive approach to mental health. Man's hostility to man is reflected in labor-management disputes, in increasing delinquency, high rates of divorce, racketeering, cheating, alcoholism, drug addiction, mental illness and war (99). Obviously there is a job to do here. The mental health problems must be solved. The savings to industry which could result from an adequate community mental health program cannot be calculated.

In most communities, the problems and needs of smaller industries have not been investigated. The majority (60 per cent or more) of the employes in the United States are in industries employing less than 500 people. The starting point is in planning to solve the needs of this group. Some communities need, and could easily support, a community center, which would economically offer to its smaller industries the accepted principles of occupational and preventive medicine, disability benefits and other insurance which are prepaid through employe-employer contributions.

In regard to the program of medical care, more emphasis must be placed on care in the home and upon stimulating a greater interest in the Central Hospital Plan. It should also include proper use of available institutions and agencies; the establishment of a program of prepaid outpatient diagnostic services and home nursing care on a co-insurance basis; an emphasis on mental health; an application of the sound principles found in private business to the administration of the hospitals themselves; complete government subsidy for the total cost of indigent care; recognition of, and an interest in, properly trained hospital personnel; and the establishment of adequate financial reserves for private general care hospitals.

Satisfying the Needs of the Physician

Industries accept the subsidization of the cost of medical care with company funds in direct relation to their ability to assume that cost. Because of the economic and insurance principles involved in this subsidization, there probably never will be more than limited amounts available to be budgeted for medical care and health maintenance.

In formulating plans for paying the costs of medical care, it appears that economists and insurance experts have avoided the fact that two-thirds or more of patients seen by the doctor have purely functional illnesses, or illnesses which have a predominantly functional component. Persons with such illnesses need not be hospitalized to be treated adequately. The payment of the costs of professional care have for the most part been limited to care for in-hospital illness. It becomes obvious then that only a small portion of the costs of professional care has been subsidized by industrially supported voluntary prepayment plans.

A large proportion of the funds paid out for professional care have up to now been paid to the surgeon. It appears that this circumstance developed because charges for surgical care were the easiest to administer in prepayment plans, and appeared on the surface to be the most catastrophic in comparison to other costs of professional care that might be paid. The interest then does not appear to have been in formulating a plan which might solve the medical care problems which confront the community.

More of the available funds should be used to subsidize part of the cost of professional care performed by specialists other than surgeons and

by general practitioners. Better results might be obtained if more emphasis were put on making available a greater percentage of funds to pay for the cost of psychiatric professional care and improved mental health programs. Statistically, as has been mentioned, the greatest needs are here, yet remedial measures to solve the problems in the field of mental health are neither being recognized nor subsidized. The general practitioner is reported to be the most important link in the chain of medical care; yet his coffers are empty of funds that should have been received from voluntary prepayment sources.

If industrial management wishes to develop a satisfactory health maintenance program, it cannot avoid recognizing the entire medical profession as it budgets for health care (146). The doctor, first of all, must receive a proper share of the total funds that are available for health maintenance. In the field of prepayment insurance, a greater percentage of the cost of physicians' fees is being assumed by the voluntary prepayment plans. The present trends support the belief that more funds will be available in these plans to pay for professional fees for purely medical services in contra-distinction to surgical services when the patient is admitted to the hospital. As a positive approach, this may accomplish little more than added abuse; however, it is a step in the right direction, because available funds for professional care must be distributed more equitably. This means that if the funds for professional care are to be limited, less of the total amount should go to the surgeon and more to other practitioners of medicine.

A program of health maintenance care will not be successful unless all physicians choose to accept and support it.

CHAPTER X

THE PROPERLY INTEGRATED HEALTH MAINTENANCE SYSTEM

People in the United States have reason to believe that (a) quality medical care is not always available, and that (b) the medical care which is available is not supplied at reasonable cost.

Although the economics of health maintenance is not necessarily its most important characteristic, some attention should be given to the costs involved and therefore to the efficiency with which the task is accomplished.

The characteristics of the present health maintenance system in the United States have been reviewed in Part I of this paper. The system obviously leaves much to be desired. However, all proponents of various plans have a common purpose - the maintenance of good health. In preparing a solution then, the problem will be approached on the basis that each proponent has good reason to believe that his plan has many advantages, some of which are conflicting. The advantages need only to be viewed in an unbiased manner; the disadvantages need to be recognized and accepted as such.

Properly to integrate a health maintenance system will require cooperative effort within the community. Since most of the people are directly or indirectly involved in some industrial process, the greatest effective force that might be used to integrate health maintenance in the United States will be found within the industrial system.

Organized with the support of industry and managed privately, the properly integrated health maintenance system will include:

(1) A system of care which will:

(a) Properly balance preventive and therapeutic medicine;

(b) Recognize the value of mental health;

(c) Stimulate more medical care in the home;

(d) Maintain the quality of medical care;

(e) Avoid government control, yet recognize government responsibilities for the care of the indigent.

(2) A plan of financing that will:

(a) Maintain the private general care hospital in private hands;

(b) Give proper recognition to all physicians;

(c) Establish the principle that government agencies will pay the full cost of health care for the indigent;

(d) Give realistic appraisal to the individual burden;

(e) Provide non-occupational disability benefits (71)

A System of Medical Care That Will Properly Balance Preventive and Therapeutic Medicine

"Sound business policy would seem to require that greater control of disease and of its associated cost be achieved by applying the best that preventive medicine can offer, and that some means be found for defining the nature, scope and magnitude of the medical and economic problem. It seems highly doubtful that responsible industrial management can afford not to take significant strides along these lines at the earliest possible time." (120). In 1948, whereas expenditures for medical care were estimated at eight

billion dollars, the loss in output due to disease and injury was estimated to be about twenty-seven billion dollars (121) (Leavell). These figures show that more emphasis needs to be placed on preventive and rehabilitative medicine.

That diseases and injuries should be prevented by application of the accepted principles of preventive medicine has been widely accepted (77) (89) (122) (121) (14) (42) (17). Preventive medicine can be developed, coordinated and applied only at the community level.

Differences of opinion lie in the methods by which prevention is to be accomplished. One solution evidently would be to encourage periodic health reviews in the family doctor's office; however this probably will never materialize (a) because of the expense to the patient, or to the prepayment system (if done on a fee for service basis); (b) because of the lack of desire of the patient to have it done; and (c) because doctors' hours are filled in satisfying the demand for therapeutic medicine.

Certain government personnel and labor leaders believe prevention should be a part of a comprehensive national prepaid health insurance system (17) (147) (157) best accomplished on a compulsory basis. There are those investigators who agree that preventive and therapeutic medicine are inseparable (14) (89). It has been suggested that mass screening tests be made available to physicians for patient referral (6) (JAMA 1951-June 16, and Aug. 11).

As a new and varied approach many authorities have recommended that community preventive medicine be accomplished as an application of occupational medicine (77) (107) (118) (123) (120) (115) (163). Such a program appears to have been accepted in France (43).

The working population is the largest segment of our entire population. The application of preventive medicine in industry is, first of all, a means of determining the health status of this group (118).

The direct responsibilities for preventive medicine in industry have been discussed in another section. However, the goal of occupational medicine is the promotion and maintenance of the highest degree of physical, mental, and social well-being of workers in all occupations. The achievement of this aim, particularly as it applies to preventive medicine, needs (a) action on a large scale and (b) medical supervision of workers in industrial health centers, where the doctors are familiar with local conditions. This supervision in small urban work places and in rural occupations is grossly inadequate (107) (123).

The practice of preventive medicine in industry will not by itself solve completely the preventive health problem. Other community health needs can be and are being met by family physicians, diagnostic clinics, and by local and state health department agencies with the assistance of the United States Public Health Service. Similarly, some of the health needs of many school children are being provided through school health programs (136) and by conscientious pediatricians in private practice. All need to be in the community preventive health program (13).

Unfortunately in many communities there is duplication of effort, of administration, and of expensive technical equipment which rapidly depreciates. In addition, an increasing percentage of diagnostic and preventive medical services is being carried out in the hospital at the expense of voluntary prepayment plans, which were not established for that

purpose. In these cases, fixed admission diagnostic services and the cost of room and board are simply added to the basic cost of the desired diagnostic procedures. Diagnostic and preventive medical services should not be provided in the hospital on an in-patient basis.

It appears that the great need is for community coordination and cooperation - to increase efficiency, avoid duplication and waste, and to make services available to more people. This can be accomplished (1) by observing the principles in the Central Hospital Plan (30) (78) (124),(2) by creating the Small Industry Health Center (43)*, and (3) by stimulating an industrial interest in solving the problems at hand (107). Preventive medical care might be made available in a system in which outpatient diagnostic services and home nursing care are provided through voluntary prepayment plans on a co-insurance basis. These services would be offered more efficiently and economically in this manner, provided they were coordinated in the community, had the support of the industries in the community, and were free from undue government control (77) (125) (30) (14) (126).

In summary then, the system of medical care that will properly balance preventive and therapeutic medicine will place more emphasis on the preventive phase. Private practitioners in general practice will perform more preventive medical services. The industrial employe will have access to an industrial medical department which will be organized to practice preventive medicine. Such a department will help coordinate the health problems of the employe by referring him to his own doctor for treatment. The industrial physician will make available to the family doctor all pertinent medical data which have been collected by the industrial medical department,

*(43) experience in France

and will recommend use of public services when it is indicated that he do so (111).

For indigent people and others not gainfully employed, it is proposed that preventive medicine be provided through local health agencies which will refer job applicants to small industry health centers or to the employment and medical departments in larger industries, where the individual will be placed on the job he can perform with due regard to his pre-determined capacity. His capacity can be determined in one of the three centers, and this medical information might be exchanged among all three.

For children of preschool and school age, who are not under the care of family doctors for one reason or another, preventive medicine might be practiced in industrially supported school health programs organized for that purpose.

Other preventive services are to be financed through voluntary prepayment plans which will pay most of the cost of outpatient diagnostic services on a co-insurance basis. Hospital confinement cannot nor need not be a prerequisite for this preventive service. The full cost of such care for the indigent and medically indigent patient is to be borne by government agencies or by voluntary agencies which will be reimbursed in full by government agencies.

A System of Medical Care that Will Recognize The Value of Mental Health

The importance of mental health has been discussed in another section

entitled "Mental Health." In summary, and with reference to that section, the properly integrated system of health maintenance care will include the following provisions:

(1) Medical and hospital care for mentally sick patients who need to be institutionalized will be financed by government agencies, as has been the custom in the past;

(2) Physicians recognizing the value of mental health for their patients, will alter their professional techniques accordingly, for example by the use of guided interviews through which they may recognize emotional illness (86) (102) (127) (128) (129);

(3) Out-patient care when feasible, will be substituted for hospital care;

(4) Ancillary diagnostic services will be accomplished in out-patient diagnostic centers, where the cost of the services are prepaid on a voluntary co-insurance basis;

(5) Physicians will admit mentally ill patients to private hospitals only when this is indicated, the professional and hospital costs being financed on a voluntary prepaid co-insurance basis;

(6) Medical departments in industry, including the small industry health center, which will be staffed by trained mental hygiene personnel, will carry out satisfactory measures for mental hygiene, Under certain circumstances, this staff may include industrial psychiatrists, psychologists, social service case workers and visiting nurses (108) (109) (127);

(7) A mental health and hygiene program in the public school system,

available to all children of school age, as well as to teachers and administrators, and financed entirely by industrial subsidy, if necessary, will be staffed by trained mental hygienists and established as an integral part of the school health programs under medical supervision.

The System of Medical Care That Will Stimulate More Care in the Home

Several of the reasons why more bed patient and ambulatory medical care should be given in the home have been presented in published reports (30) (90) (14) (126).

In addition to such reasons, there is a shortage of trained hospital personnel in all categories. Under such circumstances, hospital care may be disadvantageous to patients who receive inconvenient, ineffecient, and often inconsiderate treatment.

In some instances too, patients are admitted to hospitals solely for diagnostic purposes; and occasionally only because hospital admission is more convenient for the physician in charge of the case.

Regarding the cost factor, where the equivalent of hospital care is given in the home, its cost is reported to be less than one-fourth that of maintaining the patient in the hospital (126).

A system of medical care which will stimulate more care in the home and will provide adequate care for ambulatory patients without hospitalization, will include:

(1) Outpatient diagnostic services on a prepaid voluntary co-insurance

basis;

(2) Home nursing care similarly prepaid;

(3) Organization and administration of hospitals according to the principles advocated for the "Central Hospital Plan" (30) (78) (121) (124);

(4) Care in the home whenever possible (126);

(5) Medical treatment of patients at home, under provisions whereby the costs of medical care other than that of the physician are partially prepaid;

(6) Hospitalization only when necessary and not solely for diagnostic procedures, the costs of these admissions, including professional care being prepaid voluntarily, on a co-insurance basis.

A System of Health Maintenance Care Which Will Maintain the Quality of Medical Care

To repeat, the quality of medical care depends in part on: (122)

(1) The method of organizing the medical resources;

(2) Continuity of care;

(3) Standards of diagnosis and treatment;

(4) Extent of preventive and rehabilitative care;

(5) The nature of the patient-physician relationship;

(6) Encouragement of education and research.

This entire paper deals with the method of organizing the medical resources of the United States. Suggestions have been made concerning the responsibilities of industry as a whole and of an industrial medical department.

Recognition has been given to the needs of physicians. An attempt has been made to outline an organization for all the medical resources, this with a definite purpose - to maintain health for production, the elements of the organization being free of governmental direction and control, including the doctor, the private hospital, the health center, industry, the teaching institution, the voluntary prepayment agencies, and the individual recipient of the services.

A plan is given in more detail in previous sections entitled, "Voluntary Prepaid Health Plans (General Applications)," and "The Present and Future Hidden Responsibilities of Industry in Administering Health and Welfare Plans." The details of these sections have been correlated to fulfill the requirements for quality medical care enumerated above.

Research and education in medicine are encouraged as an integral part of the Central Hospital Plan (124) and are the bases upon which the proposed medical department in industry is organized.

Other suggestions for the structure within this plan are given in preceding parts of this section; i.e., the parts describing preventive medicine, mental health and hygiene, and the necessity for more home care.

Taken together, all maintain the quality of medical care.

A System of Health Maintenance Care That Will Avoid Government Control

By law and custom, the government has the responsibility for the care of indigent people. In regard to health maintenance for this group, government agencies have not assumed their share of the costs, if we are

to assume that indigents are to have care equal to that received by the people in self-sufficient families. As a general rule, government agencies have taken a privileged position in this field and only grant limited flat fees for services rendered.

In the proposed plan, governmental agencies will pay the complete cost of the care of each individual case to the private institution which accepts such patients and to the doctor responsible for medical care.

The system of care which will avoid government control, in addition to recognizing the above, will so operate that the government does not occupy a position of priority in case of bankruptcy of hospitals and health centers that receive federal funds. Under these conditions, a government subsidy would be acceptable and advisable for the construction of medical centers that are urgently needed. As through appropriate financial provisions, sketched below, private hospitals will remain under private management.

A Plan of Financing that will Maintain the Private General Care Hospital Within the Private Enterprise System.

Private insurance companies should withdraw from the prepayment hospitalization field, and this function should be assumed on a national basis by the Blue Cross Corporations for a number of reasons.

(1) Health care cannot be financed on a profit basis. The distinction is made here between the profit of private insurance carriers and the "reserves" of voluntary prepayment plans such as Blue Cross. The surplus funds accumulated (as profit) by private carriers are committed in

reserve to no agency except the insurance company that accumulates them. In times of recession or depression, then, these reserve funds will probably be used to salvage the insurance companies and not the hospitals or the private system of medical care.

The Blue Cross Corporations, on the other hand, have established a National Quarantee Fund to be used to assist member corporations in that system. Member hospitals are similarly under contract to accept Blue Cross patients for 90 days after funds for hospitalization may no longer be available from these corporations.

(2) Under the profit-seeking insurance approach, the hospitalization policies of the insurance companies will not be applied to groups of people known to have greater health risks. Blue Cross contracts are obligated to (and will) accept all health risks in the community.

(3) Insurance companies, for the same reasons, cannot assume the burden of unknown risks on a national scale. The hospitalization plans of the Blue Cross Corporations can be easily adjusted to assume such risks including indigents and employes in government service.

(4) In time of recession or depression, insurance companies would not be obligated to continue hospitalization benefits for people who no longer are employed in the industries which they subsidize. In fact, if the industry in question could not pay the premiums, the coverage by insurance companies, in all probability would cease. On the other hand, Blue Cross members (under similar circumstances) can continue this coverage on an individual direct pay basis, and might transfer from one group to another. They can make use of the Blue Cross System

simply by showing an identification card. Similar alternatives are offered to the dependents of the employes. In a period of crisis, recession or depression, these advantages may be decisive, if the maintenance of a private system is possible and desirable at that time.

(5) In a system in which continuity of service takes precedence over competitive advantage, unhealthy competition cannot be permitted if by so doing law and custom might be sacrificed. Private insurance companies, Blue Cross Corporations, and Blue Shield have been competing in an unhealthy manner for the preferred group risks and for volume coverage in the larger industries (56)*. This is occurring at the expense of accepted insurance principles which, as reported, were to have been observed to the letter (56)*. Such competition based on the profit motive cannot continue in the health maintenance field. Particularly is this true if the obvious needs are to be satisfied, and if funds in surplus are to be used to prepay care for people for whom the cost is too great when it is assumed on an individual basis.

This unhealthy competiton may cease when insurance companies withdraw from the prepayment hospitalization field and assume other insurance risks which properly are theirs.

Private insurance companies should restrict their coverage to benefits which can be administered under the fundamental principles

(1) 56* Part I, Page 66 (2) 56* Part II, Page 118

upon which they apparently must operate (56). For example, these companies, under a bona fide insurance program, might assume the risks for all employed people in:

(a) Non-occupational temporary and total permanent disability benefits;

(b) Industrially subsidized life insurance:

(c) Pension plans;

(d) Payment for all in-hospital professional care on a prepaid co-insurance basis. (As an alternative plan, Blue Shield agencies might assume the payment for all in-hospital professional care on a prepayment co-insurance basis.)

Blue Cross Corporations, under the proposed system, will assume the payment of hospital care, outpatient diagnostic services, and home nursing care, voluntarily prepaid. (72) (77) The plan might be administered in the personnel or insurance departments of large companies (as is now the case for most insurance benefits) and also in small industry health centers, where the cost of administration of this coverage would be assumed by the Blue Cross Corporations.

The Blue Cross Inter Plan Guarantee Fund is to continue to be the firm reserve foundation of this system (82) (83) (84). Similarly, the Blue Cross Approval Program would remain in effect, and an agreement might be considered to include in the program the agencies which are responsible for home nursing care and outpatient diagnostic services. Under Section IV of this approval plan, it is noted that Blue Cross has included in the accepted costs of service: "an allowance for depreciation of buildings and equipment and other contingencies as determined by

mutual agreement at the local level." (29) Such a plan requires increased efficiency in hospital administration as suggested and outlined in other reports (121) (30) (35) (78) (124) (126) (69) (31) (130) (131) (18) (132).

A Plan of Financing That Will Give Proper Recognition to All Physicians

It has been reported that most of the funds paid out in the past for professional care have been paid to the surgeon. For the hospitalized patient, more of the funds available from insurance programs should be used to subsidize part of the cost of the professional services of specialists other than surgeons, and of general practitioners.

The payment of the costs of professional care on a prepayment basis has, for the most part, been limited to care for in hospital illness. This phase of the present plan should continue; however, as mentioned above, benefit payments might be broadened.

Payment for the cost of professional care in the home and doctors' offices should not be included in the prepayment scheme until other more urgent needs are satisfied, since the administrative costs of handling small payments at frequent intervals has been proved to be out of proportion to the benefits received (87). Such a change would also not conform to the fundamental principles upon which insurance companies evidently must operate (56).

A Plan of Financing That Will Give Realistic Appraisal to the Individual Burden.

As a general rule, medical care is a necessity, not a luxury. Medical care need not be furnished for all people, any more than should food, clothing, or shelter. All these are individual not governmental responsibilities. Neither are they social obligations. Society through government is obligated to provide these necessities only for indigent people. Society might be expected, under certain circumstances, to provide medical care for medically indigent people, but it assumes this responsibility and obligation voluntarily, and not through law or the force of actual necessity.

Because of governmental action, supplemented by that of large industrial organizations, many employed people have been conditioned to the fact that someone else will pay part of their bills for medical care. Many more employes in smaller industries have not had this advantage. To the former, some have said (since January 1953), "the honeymoon is over." This is not true of the benefits that have developed in the health maintenance field. There is every evidence to support the view that prepaid medical care coverage will increase (155) (162).

However, above all, realistic appraisal must be given to the individual burden, partly because there is a limit to that which people can receive from industrially subsidized programs. Particularly is this so in view of the fact that inequality exists among people in the same income group. Employes in large industries receive these benefits practically without cost to themselves, whereas those in smaller industries obtain no similar benefits. There is a further reason for examining the economics of the situation, in that many people have no access to medical care of the preventive or main-

tenance type, and therefore these benefits must be spread over a broader base.

If health maintenance care is to be prepaid, there are only two alternative sources of its administration, (1) government, and (2) industry. Recent trends of thought and procedure favor the latter.

Prepayment through industry can be made feasible by a realistic adjustment of the individual burden as follows:

(1) All people of any means should pay part of the cost of the medical care that they receive. In addition to reducing the cost of prepayment care to the carrier, this will help prevent abuse.

(2) If the costs are to be prepaid, they should be prepaid for all, and not a chosen segment, of the industrial population.

(3) Since proof has been given that the administrative costs of handling small payments at frequent intervals are out of proportion to the benefits received, then, all of the cost of frequent minor items of medical care should be assumed by the individual, simply for the sake of economy (87).

(4) The principle of co-insurance should therefore be applied in all of the following categories of health maintenance care:

   (a) Hospitalization benefits,

   (b) In-hospital professional care benefits,

   (c) Out-patient diagnostic services,

   (d) Home nursing care,

   (e) Industrially subsidized life insurance and non-occupational temporary or total permanent disability benefits, and

   (f) Pension plans.

A Plan of Financing That Will Provide Non-Occupational Disability Benefits

There is a need for clarification of the part that disability benefits are to play in a properly integrated health maintenance system. Health is generally meant to encompass both medical-care insurance and temporary-disability insurance, as applied in the terms health and welfare (71).

Actually, non-occupational disability benefits are welfare benefits. However, these benefits have come to be considered as a part of a health maintenance program, when during an illness or injury, other economic necessities must be satisfied (food, clothing and shelter), which specifically contribute to the individual's overall state of health. Particularly is this true in families where there are no monetary reserves with which to satisfy the needs of the individual and of other members of the family considered to be dependent.

Regardless of the application that is made, however, non-occupational disability benefits have been accepted to be an integral part of health and welfare plans in industry and out of industry, in states having compulsory disability benefit laws,financed partly or entirely at the employer's expense (133) (134) (48) (77).

Similarly, it has been shown that these benefits affect the degree of absenteeism in an industry's working force (39) (134), especially when the level of benefits approximate the wages of the individual concerned.

In this way, and also because of the fact that industry is paying more and more of the total bill for non-occupational disability benefits, the

cost of these benefits affects production costs. By default, particularly in Rhode Island and perhaps now in other states, industry has little control over this item of operating expense (134).

If experience is to be a teacher, certainly employers can learn a lesson from the activities of others in this field. The trend appears to be that if private plans do not provide these benefits then the state will; and more and more is this being done at the expense of industry. Prudent policy makers in industry have only one course to take, if they are to retain some degree of control of these costs.

For the above reasons, and because of the fact that the industrial medical department has a basic interest in absenteeism due to non-occupational illness, the benefits for non-occupational disability should be included, functionally and administratively, in the properly integrated industrially subsidized health maintenance system, and should be financed as a part thereof, on a voluntary prepayment co-insurance basis.

CHAPTER XI

THE SMALL INDUSTRY HEALTH CENTER

Many small industries, individually, do not have sufficient funds to subsidize plans which might provide health maintenance care for their employes. The proportion of these industries in the country, and the numbers of their employes, in relation to the total industrial population are such that that much of the largest part of the problem of industrial health is yet to be solved (1) (134).

Smaller industries might provide and maintain health maintenance programs for themselves by combining their efforts and funds in a cooperative plan (107) (165). Such programs might be administered in small industry health centers.

A complete program for such a center has as yet not been developed, although the need for medical supervision of small work places has been reported previously (107) (118) (134) (1). The idea of central administration of such care for grouped industries is essentially not a new one (135).

If it is possible for the smaller industries in a community to derive the benefits of a health maintenance program from a central unit, which might economically be maintained on a private basis, then such a center should be established (18) (136) (134).

With this in mind, the basic provisions for a small industry health center are offered as follows:

(1) Financed, organized, planned, and designed primarily by the representatives of small industry, which are grouped for this purpose (70) (165);

(2) Assisted (80) (99) in all phases of its development by (a) larger industries where successful programs already are operating, and (b) private insurance carriers, (c) Blue Cross Corporations, and (d) governmental agencies (137) (143).

(3) Operated by properly trained physicians (118) (111) (120);

(4) Committed to the promotion and maintenance of the highest degree of physical, mental, and social well being of all workers (107), without practicing conventional therapeutic medicine or encroachment upon other types of medical care given by private physicians;

(5) Administered by a central agency through which welfare benefits are provided by group coverage.

Private insurance companies should be sufficiently interested in these centers to help finance them, for two reasons; (1) the property represented in the center might well be good loan investments; (2) the center will provide a nucleus from which desired insurance benefits might be processed by private insurance company personnel, on a group basis.

Blue Cross Corporations should assist in establishing such centers, because more people will be in groups for Blue Cross coverage of hospitalization and other proposed benefits (18). Many people have never enrolled in Blue Cross Plans because of the expense associated with individual direct payments. Blue Cross experience shows that if all the people in the community were covered by prepayment hospitalization, in a plan such as is offered by the Blue Cross Corporations, then hospital costs and length of stay would

decrease. The small industry health center is a prime location where the remainder of the people not yet covered by Blue Cross might be covered economically.

Government officials should be interested in such centers because they provide effective private means for satisfying the health needs of many people of small income.

In certain areas, government subsidy will probably be needed to aid in financing these centers; however once they are constructed and are operating, a continuing subsidy from government will probably not be necessary. A properly organized and administered small industry health center will be self-sufficient. Initially, government subsidy might be made available for construction purposes through laws which already have been considered in the Congress (54s) (54o).

These centers will save money for the small industries which support them, for the same reasons, and in the same manner, that the industrial medical departments of larger industries have saved money.

Although it is reported that health centers of this type are not operating efficiently in France, the organization of the French program might advantageously be applied to the problem as it exists in the United States.

The advantages of the French program are incorporated with some modifications in the following proposed organization of the small industry health center for the United States (43):

(1) Each community (where such a center can be maintained) to have a medico-social center to service small industries;

(2) The personnel in the center, as paid employes of the smaller industries, to survey industrial establishments, and to make suggestions to improve the health of the workers, state codes and regulations, and accepted principles of preventive health maintenance providing bases for the suggestions given;

(3) All persons (from industries served) who seek unemployment benefits to be sent to these centers for an appraisal of physical capacity, which will be used as a basis for re-employment, transfer, or proper job placement;

(4) Provision for pre-employment and periodic health examinations, sickness insurance (temporary and total-permanent disability benefits), life insurance and pension benefits, prepaid hospitalization, out-patient diagnostic services, home nursing care, and in-hospital professional care benefits - all on a co-insurance basis; (prepaid hospitalization, out-patient diagnostic services (125), home nursing care benefits to be provided through the Blue Cross Corporations, and all other social insurance benefits, through private insurance carriers.)

(5) Maintenance financing of social benefits, as suggested, to be on a co-insurance basis, details to be advised by the executives of prepayment carriers, both private insurance companies and Blue Cross;

(6) Compensation for disability from occupational disease and injury to be administered through the proper State agencies;

(7) In the prepaid sickness benefit program;

(a) Benefits to be partially, not comprehensively, prepaid;

(b) Employes to pay part of the cost of all benefits, (except

compensation for occupational disease and injury), such as hospitalization, out-patient diagnostic services, in-hospital professional care, and home nursing care.

(c) Compensation for the services of physicians in the home and in their office are not to be provided through prepaid insurance, but might be considered later, once the above benefits are provided for all employed people and their dependents (including farm groups) (138);

(d) Temporary disability benefits to be monetarily less than industrial wages, as is now generally the case (102);

(e) Professional fee schedules to be worked out between medical societies, Blue Cross Corporations, and private insurance carriers (or Blue Shield agencies).

It is suggested that the industrial medical service in the small industry health center be organized as follows:

(1) Industrial health services available for all of the employes of enterprises supporting the health center.

(2) Within the limits of the group, the services of industrial physicians and assistants to be essentially preventive in nature, including (120) preplacement, periodic and return to work examinations; emergency and simple on-the-job maintenance therapy (106); industrial and mental hygiene services; job transfer consultations; adequate confidential records, and appropriate reports to the supporting industries.

Details of the Industrial Medical Departments In The Small Industry Health Center

The size of the center and the number and types of persons needed to provide preventive services will depend on (1) the size of the community, (2) the number and types of industries served, (3) the number of employes served, and (4) the facilities already existing in the community.

The center might therefore include all or only a few of the following personnel:

(a) Medical director of the center (administrative head).

(b) Specialists in industrial medicine and hygiene, including dermatologists, non-medical industrial hygienists (119) (165), mental hygiene personnel (industrial psychiatrists, psychologists and social service workers (108) (109) (127), and dentists (136). (Refer also to (107) (101) (23) (139) (110) (102) (99)).

(c) Staff of nurses.

(d) Diagnostic section (clinical laboratory and X-ray).

(e) Insurance Department: (Essentially non-medical).
(Personnel from Blue Cross Corporations and from Private Insurance Companies).

(f) Administrative and clerical staff with a Records Section.

The type of building and the facilities to be provided will depend again on the community and the industries served, but the requirements in physical facilities will include private consultation rooms in sufficient

number, space and provision for confidential records, clinical laboratory and X-ray equipment, first aid space and equipment, a well equipped industrial hygiene laboratory with provision for the transport of the equipment (portable laboratory) for sampling or investigating the industrial environment, (portable consultation rooms and examining equipment have been found to be economical, convenient and satisfactory for carrying out periodic examinations and conducting surveys of employes) and other transport equipment (ambulance, passenger car).

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