

**MEDICAL CARE FOR THE
AMERICAN PEOPLE**

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MEDICAL CARE FOR THE AMERICAN PEOPLE

THE FINAL REPORT
OF
THE COMMITTEE ON THE COSTS OF
MEDICAL CARE

ADOPTED, OCTOBER 31, 1932



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INTRODUCTION

Pain, sickness, and bereavement have shadowed mankind throughout the ages; today there is a vast amount of unnecessary sickness and many thousands of unnecessary deaths. Each year, over a hundred thousand babies die during the first year of life, many of them needlessly. Of the many thousand victims of tuberculosis, over 88,000 died in 1930 alone. Pellagra and hookworm disease reduce the economic efficiency of a large proportion of the people of the South. Syphilis and gonorrhea destroy fertility, deform babies and wreck homes. Over one-third of a million persons are mentally diseased. The death rates for cancer, diseases of the heart, and diabetes are rising. A large proportion of the people, young and old, are handicapped by one or more defects—particularly decayed teeth, enlarged or diseased tonsils, defective vision, partial deafness, and weak feet. For the hundreds suffering from specific diseases, thousands are rendered inefficient for their various occupations because of common colds, constipation, headaches, rheumatism, and other minor ailments.

Yet medical science has made marvelous advances during the last fifty years. Following the work of Pasteur, Lister, and Koch remarkable progress has been made in controlling the communicable diseases, and the average length of life during this period has been greatly extended. Yellow fever and bubonic plague have been virtually eliminated in the United States. Typhoid fever and smallpox have been greatly curtailed. We have the knowledge, the techniques, the equipment, the institutions, and the trained personnel to make even greater advances during the next fifty years. We know how to do many things which we fail to do or do in an incomplete and often most unsatisfactory manner. As a result of our failure to utilize fully the results of scientific research, the people are not getting the service which they need—first, because in many cases its cost is beyond their reach, and second, because in many parts of the country it is not available. The costs of medical care have been the subject of much complaint. Furthermore, the various practitioners of medicine are being placed in an increasingly difficult position in respect to income

and facilities with which to work. The report which follows presents many phases of these various problems.

Aware of this unsatisfactory situation, some 15 leaders in the fields of medicine, public health, and the social sciences came together for a conference in Washington on April 1, 1926. Various aspects of the general problem were discussed, and the organization of a committee to carry on a program of research was suggested. This group, however, was not at once willing to commit itself to such a plan. Further study was considered necessary. A Committee of Five was appointed, therefore, to investigate the possible need for a new committee. Some seventy-five prominent citizens, both professional and lay, were consulted by mail; the response was almost unanimous in favor of creating a new organization to carry on an extensive program of research in the various economic aspects of medical care. Accordingly, at a conference in Washington, May 17, 1927 (at the time of the annual meeting of the American Medical Association) which was attended by some 60 representative physicians, health officers, social scientists and representatives of the public, the nucleus of the present Committee on the Costs of Medical Care was created, and an executive committee was appointed. A Director of Study was immediately employed to propose a program of research for the consideration of the Executive Committee and to engage the necessary personnel. After considerable study, a five-year program of research, consisting of 17 studies, was adopted by the Executive Committee on February 13, 1928. Important additions have since then been made to this list.

The Committee, for most of the five-year period, has consisted of 50 members representing the fields of private practice, public health, medical institutions and special interests, the social sciences, and the general public. The Committee has met regularly twice a year; and as researches have been completed, it has studied the data thus made available. During 1932 it had three meetings to consider drafts of the recommendations. The Executive Committee, under the efficient leadership of its Chairman, has met monthly throughout the five years, except during the summer months. It has had general administrative supervision over the Committee's work and has examined the reports on researches before they have been

submitted to the General Committee. Seldom has there been a more conscientious and devoted group attacking a social problem than those composing the Executive Committee. They have given freely of their time at a sacrifice of personal obligations. The total value of the work done by the General and Executive committees, if paid for in money, would have cost many thousands of dollars.

The Committee has been fortunate in securing an unusually well trained research staff; statistical assistants, secretaries, stenographers, and clerks also have shown a fine devotion to their work. All have labored diligently in the production of 26 reports on fact-finding studies. At the beginning of the Committee's work there was a disposition on the part of the Executive and General committees to assume responsibility for the detailed contents of these reports. As the work of the Committee developed, however, increasing freedom was given to staff members, and after the first reports of the Committee were published a statement was issued in each publication indicating that "reports are issued as the work of the particular staff member preparing them; neither the Committee as a whole nor its individual members should be considered responsible for the detailed contents of these publications."

The Committee has maintained, during the latter part of the five year period, a small public relations staff, believing that the results of its researches would not be of greatest use unless they were brought to the attention of the various professions and agencies interested and of the general public. The Committee has published not only complete reports of its studies, which are of special interest to those professionally engaged in the general fields of medicine, but it has issued also a series of abstracts, distributed without cost to various interested persons.

The work of the Committee would not have been possible had it not been for the generous support of eight foundations. They have remained in the background, but as the work of the Committee has developed, they have been most helpful in providing the necessary funds. Two foundations gave special assistance in two or three emergencies when the need for money was pressing. The Carnegie Corporation, the Josiah Macy, Jr. Foundation, the Milbank Memorial Fund, the New York

Foundation, the Rockefeller Foundation, the Julius Rosenwald Fund, the Russell Sage Foundation, and the Twentieth Century Fund have provided the financial support necessary for the Committee's own extensive five year program. The Social Science Research Council and the Vermont Commission on Country Life have each made a grant for a special study.

The American Medical Association, the American Dental Association, the Metropolitan Life Insurance Company, the National Bureau of Economic Research, and the National Tuberculosis Association have conducted supplementary studies which have been of great value to the Committee's program of study. The United States Public Health Service gave valuable assistance in the tabulation of an immense amount of statistical data gathered in connection with the Committee's study of the incidence and costs of sickness among families. Finally, state and local departments of health, visiting nurse associations, and other organizations and individuals have cooperated most generously in the field work of the Committee's various studies. The work performed without cost to the Committee by collaborating agencies and the various organizations and individuals who have assisted in the field work would otherwise have required the expenditure of a great many thousands of dollars.

The Committee is finishing its work on time. It will have published by the end of the present year 26 reports on studies.* In the course of its research, however, the Committee has encountered a number of questions which, in its opinion, need further attention. Studies on several of these problems have been outlined. Work on them has not been inaugurated because of a lack of time and funds. It is hoped that when the present Committee goes out of existence January 1, 1933, some other organization, formed for the purpose of promoting and coordinating further research in the field of medical economics, may consider the desirability of providing for these particular studies. It is hoped, both by Committee members and other interested persons, that a continuing organization may immediately be formed to promote experimentation and demon-

* Twenty-three of these have been issued prior to the publication of this report, the balance are scheduled for publication before January 1, 1933. Publication No. 1, The Five-Year Program, is not counted as a study.

strations in local communities along lines proposed in the Committee's recommendations.

With the present volume, the Committee presents its report of recommendations. It has labored during the last two or three years to discover the implications of the facts revealed by the various studies. The recommendations in the present report are based upon the data revealed in the 26 major reports on fact-finding studies, in its series of Miscellaneous Contributions, in the reports of collaborating agencies, and in a large number of documents issued by other organizations. A tentative draft of recommendations, as formulated in May, 1932, was submitted to a small group of competent professional advisers who, at the earnest request of the Committee, subjected it to frank and thorough-going criticism. The Committee owes much to the help of these advisers.

Early in the Committee's work it was expected that there would be one or more minority reports, and the Committee makes no apology for the fact that the 48 members composing the Committee at the close of its work have not reached a unanimous agreement on a series of recommendations. When the Committee was organized, an effort was deliberately made to secure as members persons representing all points of view on the problems under consideration. There are two important results of this policy. First, all interests and points of view, it is believed, have been adequately considered in the formulation of the Committee's recommendations. Second, there have been two small minority groups which, not able conscientiously to subscribe to the views of the majority, have submitted minority reports; and two other members have prepared personal dissenting statements. It should be clearly pointed out that the majority group is responsible only for the contents of the basic report, and the two minority groups are responsible only for the contents of their reports. The basic report together with the minority reports and the personal statements are all published in the present volume.

The quality of medical care is an index of a civilization. When in earlier centuries the entire time and energy of a people were consumed in providing food, clothing, and shelter

there was little left for the care of the sick and disabled. As the margin between production and the needs of mere subsistence expanded the preservation of health was one of the first needs to receive attention. Today in American civilization, health occupies a high place among accepted social values. As we emerge from the present depression and build up a surplus of income not necessary for mere subsistence, we shall do well to realize that we can invest this surplus in no better way than in the preservation of health.

Our physical and mental health is perhaps the nation's greatest asset. It behooves each community, therefore, to consider what plan will most effectively promote the health of its citizens. To each and every community in the United States which desires to provide better medical care and increased health for all its people, the Committee offers these recommendations. The report affords for the first time a scientific basis on which the people of every locality can attack the perplexing problem of providing adequate medical care for all persons at costs within their means. It is hoped that the report may thus aid materially in bringing greater health, efficiency, and happiness to all the people.

RAY LYMAN WILBUR,
Chairman.

LIST OF MEMBERS
OF THE
COMMITTEE ON THE COSTS OF MEDICAL CARE
OCTOBER 31, 1932

PRIVATE PRACTICE

LEWELLYS F. BARKER, M.D.
 WALTER P. BOWERS, M.D.
 *A. C. CHRISTIE, M.D.
 WILLIAM DARRACH, M.D.
 *GEORGE E. FOLLANSBEE, M.D.
 *M. L. HARRIS, M.D.
 J. SHELTON HORSLEY, M.D.
 *KIRBY S. HOWLETT, M.D.
 *ARTHUR C. MORGAN, M.D.
 †HERBERT E. PHILLIPS, D.D.S.
 STEWART R. ROBERTS, M.D.
 †C. E. RUDOLPH, D.D.S.
 RICHARD M. SMITH, M.D.
 WALTER R. STEINER, M.D.
 *N. B. VAN ETTEN, M.D.
 *ROBERT WILSON, M.D.
 ROLLIN T. WOODYATT, M.D.

PUBLIC HEALTH

GEORGE H. BIGELOW, M.D.
 HERMAN N. BUNDESEN, M.D.
 HAVEN EMERSON, M.D.
 JOHN SUNDWALL, M.D.
 ‡EDGAR SYDENSTRICKER
 C.-E. A. WINSLOW, DR. PH.

SOCIAL SCIENCES

MICHAEL M. DAVIS, PH.D.
 WILLIAM T. FOSTER, PH.D.
 ‡WALTON H. HAMILTON, PH.D.
 WESLEY C. MITCHELL, PH.D.
 WILLIAM F. OGBURN, PH.D.
 HENRY C. TAYLOR, PH.D.

INSTITUTIONS AND SPECIAL INTERESTS

W. IRVING CLARK, M.D.
 LOUIS I. DUBLIN, PH.D.
 ELIZABETH FOX, B.N.
 AMBROS HUNSBERGER, PHARM.
 ALFRED OWEN, D.M.D., M.D.
 W. S. RANKIN, M.D.
 MARY M. ROBERTS, R.N.
 *ALPHONSE M. SCHWITALLA, PH.D.
 WINFORD H. SMITH, M.D.
 *OLIN WEST, M.D.

THE PUBLIC

WINTHROP W. ALDRICH
 MORRIS L. COOKE, D.S.C.
 MRS. WM. KINNICUTT DRAPER
 HOMER FOLKS, LL.D.
 JOHN P. FREY
 MRS. WALTER McNAB MILLER
 WILLIAM J. SCHIEFFELIN, PH.D.
 AMELIA SEARS
 RAY LYMAN WILBUR, M.D.

Asterisks (*) indicate the eight physicians and the one layman who present the first minority report.

Daggers (†) indicate the two dentists who present the second minority report.

Double daggers (‡) indicate the two members who present separate personal statements.

A Note to the Hurried Reader

If you cannot read this report in full, the following description of its contents may guide you to the chapters which interest you most:

Chapter I outlines the present situation and states the nature of the problem. In very brief compass, it gives the highlights from the Committee's twenty-six fact-finding studies.

Chapter II enunciates the essential elements of a satisfactory medical program and discusses the three major lines of approach to such a program.

Chapter III translates these policies into terms of organization and administration. It presents the Committee's concept of an ultimate objective.

Chapter IV depicts the most significant plans and experiments now under way. The advantages and disadvantages of each of them are briefly summarized.

Chapter V gives the Committee's specific recommendations. There are five broad recommendations and under each of these are listed specific measures for putting it into effect. Some of the specific measures are less general in application than others. A thorough understanding of them requires some familiarity with Chapters II, III and IV.

Chapter VI presents the need for action and some practical immediate steps.

Two minority groups in the Committee do not fully agree with the exposition and analysis in Chapters I to IV and consequently reach different conclusions. The analysis of the problem and the recommendations of these groups are presented in a supplement. Personal statements by two other members are also included.

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RECOMMENDATIONS OF THE COMMITTEE

I

The Committee recommends that medical service, both preventive and therapeutic, should be furnished largely by organized groups of physicians, dentists, nurses, pharmacists, and other associated personnel. Such groups should be organized, preferably around a hospital, for rendering complete home, office, and hospital care. The form of organization should encourage the maintenance of high standards and the development or preservation of a personal relation between patient and physician.

II

The Committee recommends the extension of all basic public health services—whether provided by governmental or non-governmental agencies—so that they will be available to the entire population according to its needs. Primarily this extension requires increased financial support for official health departments and full-time trained health officers and members of their staffs whose tenure is dependent only upon professional and administrative competence.

III

The Committee recommends that the costs of medical care be placed on a group payment basis, through the use of insurance, through the use of taxation, or through the use of both these methods. This is not meant to preclude the continuation of medical service provided on an individual fee basis for those who prefer the present method. Cash benefits, *i. e.*, compensation for wage-loss due to illness, if and when provided, should be separate and distinct from medical services.

IV

The Committee recommends that the study, evaluation, and coordination of medical service be considered important functions for every state and local community, that agencies be formed to exercise these functions, and that the coordination of rural with urban services receive special attention.

V

The Committee makes the following recommendations in the field of professional education: (A) That the training of physicians give increasing emphasis to the teaching of health and the prevention of disease; that more effective efforts be made to provide trained health officers; that the social aspects of medical practice be given greater attention; that specialties be restricted to those specially qualified; and that postgraduate educational opportunities be increased; (B) that dental students be given a broader educational background; (C) that pharmaceutical education place more stress on the pharmacist's responsibilities and opportunities for public service; (D) that nursing education be thoroughly remoulded to provide well-educated and well-qualified registered nurses; (E) that less thoroughly trained but competent nursing aides and attendants be provided; (F) that adequate training for nurse-midwives be provided; and (G) that opportunities be offered for the systematic training of hospital and clinic administrators.

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THE PRESENT STATUS OF MEDICAL CARE

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CHAPTER I

THE PRESENT STATUS OF MEDICAL CARE

The problem of providing satisfactory medical service to all the people of the United States at costs which they can meet is a pressing one. At the present time, many persons do not receive service which is adequate either in quantity or quality, and the costs of service are inequably distributed. The result is a tremendous amount of preventable physical pain and mental anguish, needless deaths, economic inefficiency, and social waste. Furthermore, these conditions are, as the following pages will show, largely unnecessary. The United States has the economic resources, the organizing ability, and the technical experience to solve this problem.

The practice of medicine * is an art which utilizes the sciences. It is also an economic activity with definite relations to the cost of living, the distribution of wealth, and the purchasing habits of the people. Over one million American citizens make their living in this broad field, and for their services or the commodities which they sell the American people pay annually over three and one-half billion dollars. Although the Committee on the Costs of Medical Care has dealt primarily with the economic aspects of the care of illness, it has constantly remembered that medical practice is an art and a profession.

A large part of the population, in their understanding of the care of the human body and of public health, has not kept pace with the growth of scientific medicine. There is and will continue to be a lag between scientific advance and popular appreciation. The possibility of providing medical care for all depends in part on education which is frequently a prerequisite to change. The most satisfactory solution of the problem of providing adequate scientific medical service to every person according to his needs will be found only when the leaders of the public and of the professions join hands on a basis of mutual understanding, respect, and confidence.

* The word "medicine" is used in this report (as defined in Webster's dictionary) to mean "the science and art dealing with the prevention and cure or alleviation of disease." It therefore includes the private practice of physicians, dentists, nurses, and other individuals, and the work of all types of medical and public health agencies. "Medical facilities" and similar terms have the same comprehensive meaning.

As a result of a series of detailed studies * as well as personal knowledge of existing conditions, the Committee has reached certain general conclusions and made some general observations regarding the provision of medical service in the United States. These conclusions and observations follow:

Professional and Economic Status of Medicine.—As a profession, medicine has gone forward with strides during the last century and especially during the last 25 years. Its progress in understanding the human body and in perfecting techniques and instruments is almost unique in the history of civilization. Within the span of a single lifetime, the widespread utilization of anesthesia, aseptic surgery, bacteriology, physiology, and radiography has revolutionized the practice of medicine. Even during the last decade, medicine's advance in the unending warfare against sickness is little short of miraculous. Physicians and other men of science have displayed an unparalleled generosity in making available to their colleagues and thus to mankind the results of their research and inventive genius.

As an economic activity, however, medicine has made much less phenomenal progress. The predominant economic institution in medical practice today—private individual practice—dates back to ancient times. Under this system medical services are now so provided that many persons either cannot and do not receive the care they need, or are heavily burdened by its costs. At the same time, many of the practitioners and the agencies which provide medical service are inadequately occupied and poorly remunerated. A barrier—in large part economic—stands between practitioners, able and eager to serve, and patients who need the service but are unwilling or unable to pay for it.

Number and Distribution of Medical Facilities.—Nearly 1,100,000 persons in the United States devote all or a large part of their time to providing medical service and from it derive their livelihood. About one-half are private practitioners; the other half serve in medical institutions or are engaged in

* For a summarizing statement and analysis of the factual data resulting from the Committee's studies, the reader is referred to Publication 27, "The Costs of Medical Care—The Economic Aspects of the Prevention and Care of Illness" which constitutes a companion volume to this report. It is called hereafter "Summary Volume" and is quoted extensively without further acknowledgment. A full list of the Committee's publications is given at the end of the present report.

the sale of medical commodities. (Table 1.) There were in 1930 nearly 7,000 hospitals, with a total capacity of slightly under 1,000,000 beds. (Table 2.) In 1928 over 63 per cent of hospital beds were under governmental control. By 1931 this percentage had increased to 66, and 73 per cent of all patient-days of service were rendered by these governmental institu-

TABLE 1
PERSONNEL ENGAGED IN THE PROVISION OF MEDICAL CARE AND
THE SALE OF MEDICAL COMMODITIES*

Personnel	Private Practice	Medical Institutions or Sale of Commodities
Physicians	121,000	21,000
Dentists	56,800	5,600
Graduate nurses	118,000	77,000
Student nurses . . . . .	.....	80,000
Public health and industrial nurses . . . . .	.....	18,800
Practical nurses	150,000	.....
Midwives	47,000	.....
Chiropodists	4,900	.....
Optometrists	20,200	.....
Osteopaths	7,700	.....
Chiropractors	16,000	.....
Naturopaths	2,500	.....
Religious healers	10,000	.....
Pharmacists . . . . .	.....	132,000
Lay personnel in hospitals, clinics and public health agencies . . . . .	.....	196,000
Grand total	554,100	530,400
	.....	1,084,500

* With a few minor exceptions, the data are derived for the year 1929. Those items which are culminated from records for other years (1928, 1930, 1931) do not change the totals or the proportions in any substantial degree.

tions. Nearly 8,000 clinics and out-patient departments of hospitals, about 60,000 drug stores, and a small number of private laboratories and other medical institutions are available. Every state and large city, many of the smaller cities, and a few rural areas are now served by health departments with full-time personnel. These are the facilities on which the American people rely for the prevention and cure of disease.

These facilities, however, are not distributed primarily according to needs, but rather according to real or supposed

ability of patients to pay for service.¹ * As a result, many communities are undersupplied with practitioners, hospitals, and other facilities, while others have a surplus. For example, in 1929 there was one physician to every 1,431 persons in South Carolina, as contrasted with one to every 571 in California and one to every 621 in New York State. In 1928, there were 19 dentists per 100,000 population in Mississippi, and 101 in Oregon. Of the 3,072 counties in the United States, only 1,765 in 1928 had hospitals for general community use. Wisconsin had one bed for community use to each 154 persons, while South

TABLE 2
NUMBER OF HOSPITAL BEDS IN THE UNITED STATES, 1930

Class of Hospital	Control		Total
	Governmental ^(c)	Other	
General ^(b)	115,160	261,311	376,471
Nervous and mental ^(c)	413,347	16,844	430,191
Tuberculosis.....	50,079	13,510	63,589
Special ^(d)	8,011	17,409	25,420
Institutional.....	20,424	6,808	27,232 ^(e)
Total.....	607,021	315,882	922,903

- (a) Includes beds controlled by town, city, county, state and Federal governments.
 (b) "General" includes industrial and surgical.
 (c) "Nervous and Mental" includes feeble-minded and epileptic.
 (d) "Special" includes maternity; convalescent and rest; isolation; children's; eye, ear, nose and throat; orthopedic; skin and cancer; drug and alcohol; chronic and incurables; trachoma; venereal; and others.
 (e) These beds allocated between governmental and other types of control on basis of the ratios for each type in 1928.

Carolina had one to each 749 persons. Similar conclusions are reached from data on other states.² There is also a maldistribution by type. For example, approximately 45 per cent of the physicians of the country have completely or partially limited their practice to a specialty, although apparently the needs of the people could be met adequately if not more than 18 per cent of physicians were specialists.

Medical Service Needed and Received.—In a nation-wide survey of illnesses and costs of medical service among 9,000 white families, the Committee found that there was substantially the same incidence of illness per family or per individual in the

* The reader will find all the reference notes to this chapter assembled at the end of the chapter with numbers corresponding to those in the text.

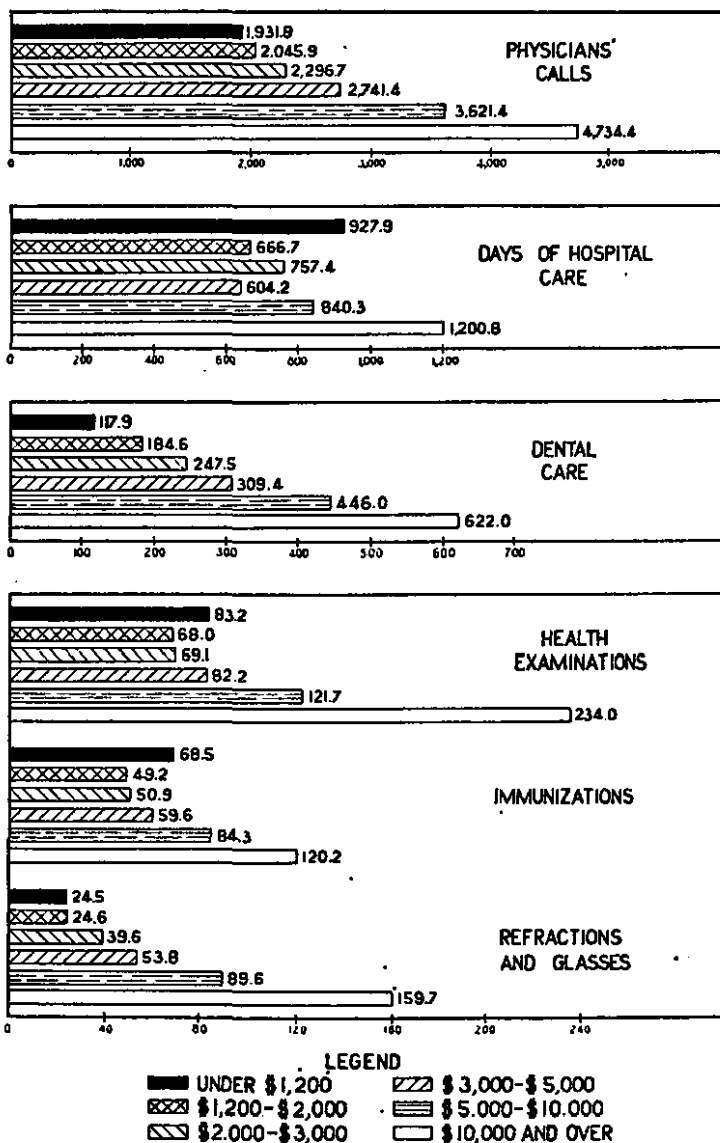


FIG. 1. THE RELATION OF INCOME TO THE VOLUME OF MEDICAL CARE

These four diagrams show, with a few exceptions, that as the income of families increases the volume of medical care received by individuals in these families increases. It will be observed that in some instances persons in the lowest income group obtain more care than those in the next higher income group; this is doubtless due to the availability of free care from private practitioners, hospitals, or health departments.

The graphs show units of medical service received per 1,000 individuals in families with specified incomes. These data are based on the experience of 88,868 white persons in 8,689 families surveyed for 12 consecutive months, 1928-1931. The term "dental care" refers to the number of persons over three years of age receiving any dental care during a 12 months' period. The various qualifications regarding these data are given in Table 3.

various broad income groups.* Families with incomes under \$1,200 or \$2,000, however, receive far less medical service than those with incomes of \$5,000, or of \$10,000 and over. This is shown in Table 3, which gives the relative amounts of service of various kinds received in a twelve-month period by nearly 9,000 families, at different income levels, in all population groups.

It is evident from Table 3 that the two or three lowest income groups receive far less of nearly every service—care from physicians and dentists, hospitalization, eye care, health examinations, immunizations, special nursing, maternity care, and x-ray and laboratory service—than the groups with highest incomes. The group with the lowest amount of service (which was not in every case the group with the lowest income) received only 50 per cent as many days of hospitalization, and 41 per cent as many calls from physicians as the group with the highest amount of service. In every instance the latter is the group with the highest income. Only one-fifth as many persons in the lowest income group receive any dental attention. The families with incomes of \$1,200 to \$2,000 receive even less hospitalization and preventive services than do the families with incomes under \$1,200.

Some persons may object, however, that the higher income groups receive more service than they need, because they enjoy the luxury of being attended by physicians and nurses, or are being kept under treatment to serve the economic interest of the practitioners. While occasional cases of these types are known to everyone, a comparison of the services received by the high-income groups with the standards for good medical care published by the Committee^a shows that, even among the highest income group, insufficient care is the rule. The only services which this group uses more than appears to be necessary are special nursing of hospital patients and the hospitalization of surgical patients. For all the other services listed, including even prenatal and postnatal calls to

* The incidence of recognized and recorded illness in the Committee's study was lowest in the low income groups and highest in the groups with highest income. It is not known to what extent the higher rate in the upper income classes is due to economic and social factors rather than to strictly physical factors. Data from the U. S. Public Health Service and other sources indicate that when the groups with incomes under \$1,500 or \$2,000 are further subdivided, a definite relation appears between poverty and illness, the lower income groups having more illness and illness of longer duration. (Miscellaneous Contributions No. 9.)

TABLE 3
THE MEDICAL SERVICES NEEDED AND RECEIVED

Units of Medical Service Received per 1,000 Individuals or per 1,000 Illnesses in Families with Specified Incomes Compared with Services Needed to Meet Standards of Good Medical Care. Data on Services Received, Based on 38,668 White Persons in 8,639 Families Surveyed for Twelve Consecutive Months, 1928-1931.

Unit of Service	Services in Families with Specified Income						Services Needed to Supply Good Medical Care
	Under \$1,200	\$1,200-\$2,000	\$2,000-\$3,000	\$3,000-\$5,000	\$5,000-\$10,000	\$10,000 and Over	
Number per 1,000 Individuals							
Home, office and clinic calls (physicians) ^(e) . . .	1,931.9	2,045.9	2,296.7	2,741.4	3,621.4	4,734.4	5,649.5
Hospitalized cases ^(b)	59.4	52.4	59.4	63.1	79.3	98.0	107.0 ^(c)
Days of hospital care ^(c)	927.9	666.7	757.4	604.2	840.3	1,200.8	1,384.7
Dental care (persons over 3 years of age)	117.9	184.6	247.5	309.4	446.0	622.0	1,000.0
Health examinations ^(d)	83.2	68.0	69.1	82.2	121.7	234.0	941.9
Immunizations ^(e)	68.5	49.2	50.9	59.6	84.3	120.2	185.3
Refractions or glasses	24.5	24.6	39.6	53.8	89.6	159.7	175.0
Home and office calls (Secondary practitioners and cultists)	154.6	139.1	230.4	231.1	459.0	569.2	....
Number per 1,000 Illnesses							
Hospitalized cases ^(b)	74.0	65.1	71.6	71.6	80.1	88.2	121.2
Surgical cases hospitalized	44.2	42.0	49.6	48.1	58.6	62.6	51.3
Cases having X-ray	23.8	25.2	27.0	31.0	48.5	75.4	186.4
Cases having laboratory service	51.7	61.6	68.8	82.8	120.3	132.3	581.7
Prenatal or post-natal calls ^(f)	6,939.0	7,230.0	9,551.0	11,386.0	12,382.0	13,000.0	19,360.0 ^(g)
Hospitalized cases having special nursing ^(h)	67.0	125.0	164.0	251.0	379.0	685.0	578.0 ^(c)

(e) For illness only. Excludes calls for preventive service.

(b) One day or longer in all hospitals.

(c) Excludes care in tuberculosis sanatoria and mental hospitals.

(d) Includes well-baby care.

(e) Includes service whether or not accompanied by illness.

(f) Rates per 1,000 maternity cases. Excludes calls in hospital.

(g) All calls, including those in hospital.

(h) Rates per 1,000 hospitalized cases in all hospitals. Restricted to cases involving 1 day or more of hospital care.

maternity patients and immunizations and health examinations, the wealthy families receive less service than these reasonable standards require. The most significant numerical measures of the adequacy of services are the number of home, office, and clinic calls by physicians and the per capita number of days of hospitalization. Of these two items, the well-to-do patients received 84 and 87 per cent, respectively, of the "standard" amounts.

The groups with smaller incomes obtain far less service. In spite of the large volume of free work done by hospitals, health departments, and individual practitioners, and in spite of the

TABLE 4
PERSONS NOT RECEIVING CARE

Percentage of Individuals Receiving No Medical, Dental, or Eye Care—Based on 38,668 White Persons in 8,639 Families with Known Incomes, Surveyed for Twelve Consecutive Months, 1928-1931.

	Percentage of Individuals in Specified Income Classes						
	Under \$1,200	\$1,200-\$2,000	\$2,000-\$3,000	\$3,000-\$5,000	\$5,000-\$10,000	\$10,000 and Over	All Incomes ^(e)
Receiving no medical, dental, or eye care ^(b)	46.6	42.2	37.3	33.4	24.4	13.8	38.2

(e) Weighted for proportions in the several income classes.

(b) The situation is actually even more startling than appears from these data because many of the persons who are counted as having had medical care may have had extremely little.

sliding scale of charges, it appears that each year nearly one-half of the individuals in the lowest income group receive no professional medical or dental attention of any kind, curative or preventive.* (Table 4.)

The figures in Tables 3 and 4 give only a partial picture of the lack of medical service. Suitable indices are not available, for example, to show the widespread lack of mental hygiene services. Although the needed data on this point are not available, there is agreement of experts in the field that the present service is seriously inadequate. A major objective of the mental hygiene movement is "the development of more real treatment facilities for the early cases found in every community.

* Actually this is an understatement. See footnote (b) to Table 4.

The thing every mental hospital superintendent faces is the fact that had such facilities existed, a large number of (his) cases would never have developed to the point where hospital care was an emergent necessity." "Early detection is fundamental. We have yet to work out methods for such detection, to train specialists in them, and to develop in the medical profession as a whole a knowledge of what can be achieved and how and where assistance can be found.

The Committee's survey does not include data for Negroes. It is well known, however, that the 10 per cent of our population who are colored have health problems which are, on the whole, considerably more serious than those of whites. The Negro is America's principal marginal worker,⁵ and he suffers in the North as well as the South from the many disabilities that this entails: poorer housing, less adequate diet, less sanitary surroundings, more employment of married women, and greater economic insecurity. The extensive migrations of Negroes during the last 20 years have added new complications to their problems. Although Negroes have lower death rates than whites for a few diseases, rates double or more than double the rates of whites are recorded for tuberculosis, organic heart disease, acute and chronic nephritis, cerebral hemorrhage, pneumonia, typhoid fever, whooping cough, bronchitis, puerperal conditions, influenza, malaria, and pellagra.⁶ Not only are death rates higher, but so also is the incidence of illness, at least from certain diseases. Syphilis, for example, is nearly two and one half times as prevalent among Negroes as among whites.⁷ Because Negroes generally are poorer than whites, it is safe to assume that on the average they receive relatively less medical service than that received by the two lowest income groups shown in Table 3. In a representative sample of over 500 Negroes in Tipton County, Tennessee, who had syphilis, only 14 per cent had received any professional medical treatment whatsoever, and less than 3 per cent had been given both nearsphenamine and mercury.⁸ In the South, the lack of care for Negroes is only a part of a larger problem. Because of the extreme poverty of large areas, neither Negroes nor whites receive anything but the most deplorably inadequate medical service.⁹

Finally, medical attention may be statistically adequate but

of poor quality. Even conceding adequate original education and training, in view of the rapidly increasing body of scientific medical knowledge, it is difficult for a considerable percentage of practitioners under present circumstances to keep up-to-date.

The Situation in Dental Care.—The average annual expenditure for dental care is extremely low among the 90 per cent of families with incomes under \$5,000. Thus among families with incomes of \$1,200 to \$2,000, the average annual expenditure for dental care is \$9.01. Families with these incomes or less constitute one-half of the total population. Families with incomes of \$2,000 to \$3,000, according to the Committee's nation-wide survey of illnesses and costs, spend an average of \$16.39.

The significance of these figures is found when we go behind the general averages. If individuals instead of families are considered, only 10.1 per cent of persons in families with incomes under \$1,200 received any kind of dental attention during the year. For those with family incomes of \$1,200 to \$2,000, the percentage receiving dental care was only 15.5. In the \$2,000 to \$3,000 income group, the percentage rose only to 21.4, whereas for the \$5,000 to \$10,000 income group it was 40.6, and for the group with incomes of \$10,000 and over it attained a peak of 59.6 per cent. Among the mass of the population, only 21 per cent of individuals secure any dental care during an average year.

Undoubtedly a certain proportion of persons secure care only for the relief of pain or other dental emergency. The proportion of the population who receive systematic and sufficient dental care must be considerably less than 21 per cent. The need for systematic dental care is unquestionable. That there is a latent demand for it is attested by the fact that the great majority of people in the higher income groups purchase a considerable amount of dental service.

Probably over 60 per cent of the \$445,000,000 expended annually for dentists' services comes from the 25 per cent of the population with incomes of \$3,000 or more. The studies of the Committee on Dental Practice of the American Dental Association show that there is unused time among dentists, although not as much as there is among physicians. Undoubtedly, a lack of popular appreciation of the value of systematic dental care is one of the reasons why dental service is not

obtained. But the economic deterrent is probably a more important obstacle.

Use of Preventive Medical Services.¹⁰—Although many practitioners suffer enforced idleness, the American people need far more of the medical services which could be provided on the basis of present knowledge and facilities. This is particularly true of preventive services.* For example, in any one year less than seven per cent of the population have a complete or partial physical examination, and less than 5 per cent are immunized against diphtheria or some other disease. In a special survey of pre-school children, the White House Conference learned that only 51 per cent of city children, and only 37 per cent of rural children, have had one or more health examinations prior to their sixth birthday; that only 13 per cent of children in both urban and rural districts have received a dental health examination by their sixth year; that only 21 per cent of city children and only 7 per cent of rural children have been vaccinated by the time they are six; and that only 21 per cent of urban and only 18 per cent of rural children have been immunized against diphtheria.¹¹

Several factors cause this limited utilization of preventive medical services. First, most laymen because of habit hesitate to seek medical care except when driven by pain or discomfort. Second, payment on a fee-for-service basis is a greater economic deterrent to the utilization of preventive services than of therapeutic work. Third, in some rural areas, medical practitioners and other facilities are actually unavailable, and, even in cities where there is an ample supply, the training of many practitioners and the avowed scope of many hospitals and clinics cause them to pay little attention to the preventive aspects of service. Finally, the physician who is aware of a patient's needs for preventive work may refrain from urging it because he does not wish to appear to solicit practice.

Public Health Services.—In view of the potential ability of public health activities to raise the general level of health at

* The actual effect of preventive medical services in reducing illness and disability is difficult to measure because of the multiplicity of factors involved. Very strong new evidence has recently been provided in an unpublished study of the United States Public Health Service of the sickness experience of nearly 6,000 employees of a large rubber company. Sickness records for 1921 to 1926 were compared with similar data for 1926 to 1930. The author of the study, Dean E. Brundage, believes that the per capita reduction for males of 32 per cent in the number of disabilities and 26 per cent in the number of work-days lost and the slightly smaller reductions for females are due, in substantial part, to the preventive efforts of the company.

relatively low cost, American communities have been pitifully backward in utilizing modern public health procedures. Of the entire \$30 per capita spent for the prevention and care of disease, only \$1 has been used for public health service, Federal, state, and local. The gross inadequacy of present expenditures is illustrated by two examples. First, the current expenditure is 65 to 80 cents per capita in American cities with populations of approximately 100,000 whereas satisfactory service calls for \$1.79 to \$2.13.* Second, in contrast with current expenditures of less than 35 cents per capita for county and rural health work, certain studies indicate that a comprehensive public health program in such areas calls for approximately \$2.50 per capita.

Niggardly appropriations for public health work not only seriously limit present activities, but also hamper medical schools in their efforts to attract competent students to public health careers, thus weakening the public health work of the future.

Present Total Costs of Medical Service.—Medical care has always been and will undoubtedly remain essentially a personal service. Contrary to the trend in most other human activities, an increased division of labor (specialization) and a larger capital investment in buildings and equipment have in general tended to increase costs rather than decrease them.

The people of the United States, in 1929, spent 3,656 million dollars¹² for all forms of medical service, including those services purchased indirectly through taxes and other community funds. (Table 5.) This is approximately \$30 per capita, per annum, and in 1929 constituted about four per cent of the money income of the country. This expenditure is not excessive for the population *as a whole* in view of the national expenditures in 1929 for tobacco, toilet articles, and recreation (5,807 million dollars) or for automobile use and other travel (9,475 million dollars). In fact, it is probable that, with a better distribution of the burden and with the growth of national income which is probable in the next two or three decades, far larger amounts will be spent advantageously and without hardship. An increased national income can be used in only three ways: to purchase more consumer's goods, to purchase more

* Exclusive of the cost of hospitalization of communicable cases.

services, or to provide savings. Since the country is now suffering, in part, from an excess of savings in the form of capital goods, a large increase of productive facilities is not called for. While there is at present underconsumption of food, clothing,

TABLE 5
TOTAL EXPENDITURES FOR MEDICAL CARE^(a)
(All Figures in Thousands of Dollars)

Service	Total	Sources of Funds			
		Patients	Governments	Philanthropy	Industry
Physicians in private practice ^(b)	\$1,090,000 ^(c)	\$1,040,000 ^(c)	....	....	\$50,000
Dentists in private practice ^(b)	445,000 ^(c)	445,000 ^(c)	....	....	....
Secondary and sectarian practitioners..	193,000	193,000	....	....	....
Graduate nurses, private duty.....	142,000	142,000	....	....	....
Practical nurses, private duty.....	60,000	60,000	....	....	....
Hospitals: operating expenses.....	656,000	278,000	\$300,000	\$ 54,000	24,000
Hospitals: new construction.....	200,000	....	100,000	100,000	....
Public health.....	121,000	....	93,500	27,500	....
Private laboratories ^(d)	3,000	3,000	....	....	....
Orthopedic and other supplies ^(d)	2,000	2,000	....	....	....
Glasses ^(d)	50,000	50,000	....	....	....
Drugs ^(d)	665,000	665,000	....	....	....
Organized medical services ^(e)	29,000	7,790	16,000	210	5,000
Total.....	\$3,650,000	\$2,885,790	\$509,500	\$181,710	\$79,000

(a) With a few minor and unimportant exceptions, the data apply to the year 1929. They are probably representative of any normal year of recent times.

(b) Physicians and dentists holding part-time salaried positions are included with private practitioners. Expenditures for the services of those employed in hospitals, clinics, public health departments, and organized medical services are included under total expenditures for the respective agencies.

(c) These totals include payments by government and philanthropic agencies to private practitioners for services to indigent persons.

(d) Includes only those expenditures which are not included in other items.

(e) University, industrial, and Army and Navy medical services exclusive of hospital care.

housing, and of commodities in general, the increase in the national income during the next ten or twenty years would yield the largest satisfactions if a large proportion of it were spent for services, especially for medical care, education, and cultural pursuits.

Without an increase in the national income, however, larger

returns may be obtained by a redirection of part of the nation's present expenditures. Of the 3,656 million dollars spent annually for medical service, 125 million dollars is spent for the services of osteopaths, chiropractors, naturopaths and allied groups, and faith healers, and 360 million dollars for "patent medicines." Much of the former sum and practically all of the latter are wasted. Possibly even greater sums are wasted through inferior services rendered by some licensed physicians and dentists, and through the inadequate use of general hospitals and of the time and equipment of practitioners. In spite

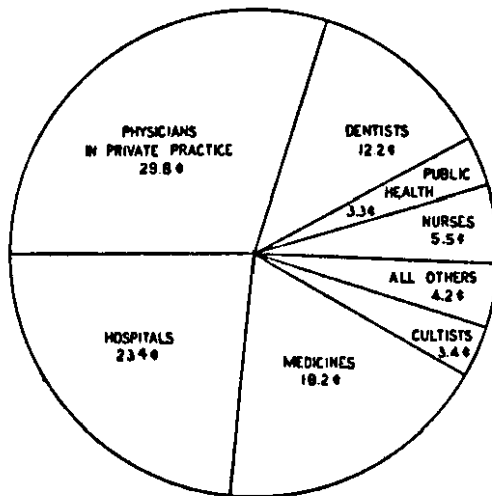


FIG. 2. OUR MEDICAL DOLLAR

Based on data from Table 5, which shows the distribution of the nation's total medical bill of \$3,656,000,000 for the year 1929.

of these wastes, the total amount of the national expenditure for medical service is, in the Committee's opinion, reasonable.

Incomes of Families.—A comparison of total national costs of medical care with total national incomes does not, however, reveal the situation faced by the individual family. In the first place, incomes in the United States are so distributed that relatively few families have an income as large as the arithmetic average. Approximately 50 per cent of all families of two or more members had, during 1928, total annual incomes of less than \$2,000, and 40 per cent more had incomes of \$2,000 to \$5,000.¹⁸ (Table 6.) An estimate of the distribution of "individual income recipients" in 1928 indicates that 80 per cent

of them had incomes of less than \$2,000 and 95 per cent less than \$3,000.¹⁴

Furthermore income is disproportionately distributed among various geographical sections. Although the population as a whole had a per capita income in 1926 of \$735, in the Middle Atlantic states the per capita income was \$1,039, and in the East South Central states (Kentucky, Tennessee, Alabama, and Mississippi) only \$369. In 1919 the ten states with the lowest per capita incomes were: Alabama \$321, Mississippi \$328, Tennessee \$346, Arkansas \$352, North Carolina \$367, Kentucky \$378, Georgia \$379, South Carolina \$390, Virginia

TABLE 6
ESTIMATED DISTRIBUTION OF FAMILIES OF TWO OR MORE
PERSONS ACCORDING TO FAMILY INCOME, 1928^(*)

Family Income	Per Cent	Cumulative Per Cent
Under \$1,200.....	15.0	15.0
\$1,200- 2,000.....	34.8	49.8
2,000- 3,000.....	24.6	74.4
3,000- 5,000.....	15.7	90.1
5,000-10,000.....	7.0	97.1
10,000 and over.....	2.9	100.0
All incomes.....	100.0	100.0

(*) This distribution of income is based upon provisional estimates prepared for use in the studies reported in Publications No. 25 and No. 26. These proportions were used in the weighting of data accumulated in the Committee's survey among 9,000 families. A further discussion of income distribution and the results of more recent computations will be found in Publication No. 25.

\$407, and Florida \$408. By 1926 substantial changes had not occurred in the per capita incomes of the regions in which these states are located. Even less-than-average charges for medical service, therefore, are more than many of our families can bear.

Distribution of Costs.—The primary reason why the costs of medical care cause complaints is that the costs are uneven and unpredictable. The disparity for a large majority of families between *average* incomes and *actual* incomes is matched by an equal or greater disparity between average and actual costs of medical care. This was clearly indicated in the Committee's comprehensive study of the costs of medical service to 9,000 white families.¹⁵ Of the families with annual incomes under

\$1,200, 80 per cent belonged to the group in which charges for medical service were less than \$60 a year. At the other extreme, one per cent of these low income families were charged \$500 or more for their medical service during the year, and 2.5 per cent were charged \$250 to \$500. (Table 7.)

The 80 per cent of the families who had charges * of less than \$60 per family incurred only 31 per cent of the total bill for this

TABLE 7
THE DISTRIBUTION OF SICKNESS COSTS

Percentage of Families with Specified Annual Charges for Medical Care Compared with Percentage of Total Charges to Families
(Based on data from 8,581 white families with known income and known total charges, surveyed for twelve consecutive months, 1928-1931)

Total Annual Charges per Family	Per Cent of Families and of Charges, for Families with Specified Income											
	Under \$1,200		\$1,200-\$2,000		\$2,000-\$3,000		\$3,000-\$5,000		\$5,000-\$10,000		\$10,000 and Over	
	Families	Charges	Families	Charges	Families	Charges	Families	Charges	Families	Charges	Families	Charges
Under \$60	79.5	31.3	68.9	23.6	54.4	14.1	40.2	8.0	27.9	3.3	11.7	0.7
\$ 60- 100	9.9	15.5	12.9	14.7	16.2	13.4	17.4	9.7	12.5	3.9	4.1	0.6
100- 250	7.1	22.3	13.0	29.3	20.6	33.9	28.3	31.6	29.6	19.1	33.7	12.1
250- 500	2.5	17.8	4.0	19.5	6.6	23.0	9.7	24.8	17.3	24.3	17.7	12.3
500 and over . . .	1.0	13.1	1.2	12.9	2.2	15.6	4.4	25.9	12.7	49.4	32.8	74.3
All charges	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

entire income group, while the 3.5 per cent with charges of \$250 or over per family also incurred 31 per cent. In other words, less than 4 per cent of the families collectively incurred

* Throughout this section the charges have been used to represent the actual costs. This is permissible since the total charges reported were equal to 95.9 per cent of the total expenditures reported. However, this ratio varies slightly with the family income and somewhat more with the amount of the total annual expenses. Thus the ratio for all families with incomes of less than \$1,200 was 92 per cent; for all families with incomes over \$10,000 it was 101 per cent. In the lower income groups particularly, those families with small bills during the year paid more than their charges for that year i. e., paid something on indebtedness from a previous period, while those with large bills paid less than their charges. (Publication No. 26.) There may, also, have been a tendency among the families not to report charges that were not paid as fully as those that were paid. Data from physicians indicate that the average difference between their charges and collections is about 20 per cent. There is evidence, however, that physicians are more often unpaid than are other practitioners or agencies.

as much as 80 per cent incurred collectively. Table 7 gives similar data for other income groups. This uneven distribution is found in about the same degree in all the groups studied, regardless of family income or location.

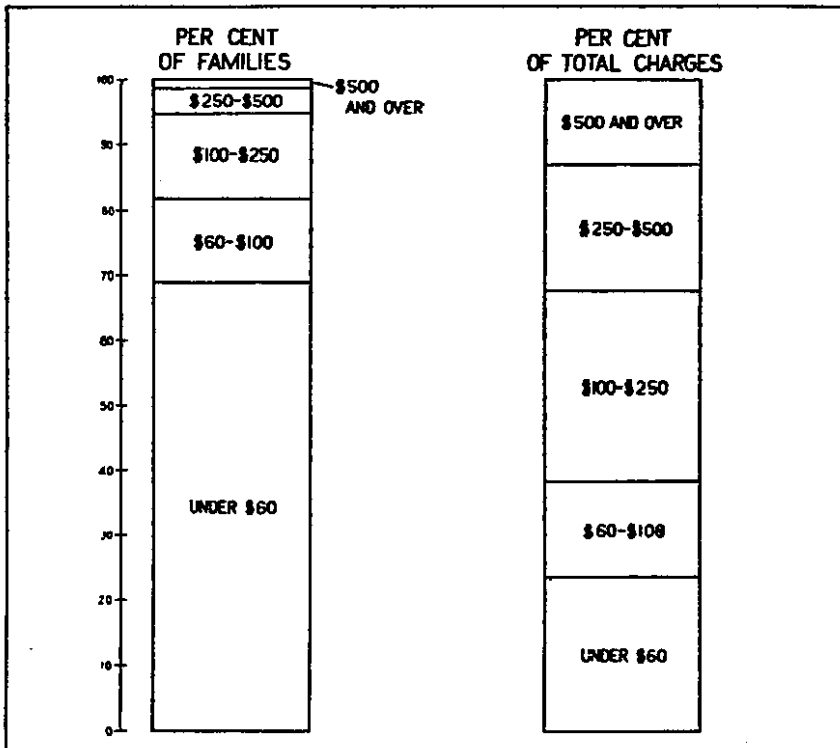


FIG. 3. THE UNEVEN DISTRIBUTION OF THE COSTS OF MEDICAL CARE

This diagram shows that, while 69 per cent of families with incomes of \$1,200 to \$2,000 had charges of less than \$60, these families incurred only 24 per cent of the total charges for all families in this income group. At the other extreme, the one per cent of families with charges of \$500 or over incurred 13 per cent of the total charges for the group. A similar unevenness is found among families in all other income groups.

Based on charges to 2,815 white families who resided in communities of various sizes, whose charges are known, and who are known to have incomes of \$1,200 to \$2,000, surveyed for 12 consecutive months, 1928-1931.

No one fact is more clearly demonstrated by the Committee's studies than this one: that the costs of medical care in any one year now fall very unevenly upon different families in the same income and population groups. The heart of the problem, therefore, is the equalizing of the financial impact of sickness.

The individual family derives no comfort from the knowledge that the *average* cost of medical care is not excessive for families with the *average* income. If a family lays aside for medical costs 4 per cent of its annual income (say \$110), it may spend only \$10 or it may spend \$1,000. The budgeting of family income, which has been encouraged of late years and has been greatly facilitated by the use of installment payments, may assist families in planning for expenditures which can be determined in advance. But the unpredictable nature of sickness and the wide range of professional charges for nominally similar services render budgeting for medical care on an individual family basis impracticable. On the present fee-for-service basis, it is impossible for 99 per cent of the families to set aside any reasonable sum of money with positive assurance that that sum will purchase all needed medical care.

Responsibility for Uneven Costs.—The costs to the family may be greatly affected by the occurrence of serious illness. If an illness requires hospital care in addition to professional services, it alone may entail costs which are catastrophic for the family. In the experience of families in the \$2,000 to \$3,000 income group living in cities of 100,000 or more people, those families who used any hospital service had average total medical charges for the year of \$261, while those who had no hospital care reported total charges of only \$67. For families with incomes of less than \$1,200 the average hospitalized illness cost \$67; at the other extreme, families with incomes over \$10,000 were charged \$470. Although, on the average, only one family in five and only one person in seventeen receives hospital care in the course of a year, illnesses which involve hospitalization are responsible for 50 per cent of the total charges for medical care. Part of this expenditure goes to the hospital, part to the physician, and part to the nurse.

The variations in total charges are obviously due to variations in some or all of the main component items in the total. Which services cause variation and how much does each cause? These questions may be answered statistically by an appeal to the insurance principle. Insurance is essentially a device by which average charges are substituted for variable charges. For each family (in three income groups) the average charge for each major type of service was substituted for the actual

charge incurred, all other charges being held constant. Similar substitutions were made for various combinations of services. It then became apparent how much of the variation was eliminated by this procedure and, similarly, how much of the variation was due to each service or each combination of services. The data for three income groups were studied separately.*

TABLE 8
THE RESPONSIBILITY FOR VARIATION IN CHARGES
The Effect of Substituting Average for Actual Charges Among Families in Three Income Classes

Service for Which Average Charges are Substituted	Family Income		
	\$1,200 to \$2,000	\$3,000 to \$5,000	\$5,000 to \$10,000
	Per Cent of Families with Residual Total Charges between		
	\$40 and \$100	\$100 and \$200	\$200 and \$500
No substitutions.....	30.0	25.5	23.8
Physician.....	55.7	31.4	36.0
Physician plus dentist.....	87.1	38.7	46.7
Hospital.....	38.4	29.6	27.8
Hospital plus nurse.....	40.5	33.7	35.5
Physician plus hospital.....	85.5	37.9	43.7
Physician plus hospital plus nurse.....	87.1	45.3	71.8
Physician plus hospital plus nurse plus dentist..	91.7	96.6	99.2
All services for hospitalized illness.....	53.0	35.9	55.8
Average actual charges....	\$69	\$132	\$284

Table 8 shows the results. Among families with incomes of \$1,200 to \$2,000, for example, only 30 per cent actually had charges between \$40 and \$100, the presumed range of reasonable charges for this group. If an insurance plan should meet physicians' charges, however, 56 per cent of the families would be in this group. Insurance for both physicians and dentists'

* Because of the complexity of the analysis, it was restricted to families in cities of 5,000 to 100,000 population and to families with incomes of \$1,200 to \$2,000, \$3,000 to \$5,000, and \$5,000 to \$10,000. There is no reason to suppose that further tabulations would materially change the results.

charges would bring 87 per cent within the "reasonable" range, and insurance for all four services raises the percentage to 92. The remaining eight per cent all would have had charges over \$100, if they had been paying only average charges for the four specified services. This is the only income group in which substitutions for as few as two services bring more than one-half of the families within the range of "reasonable" charges.

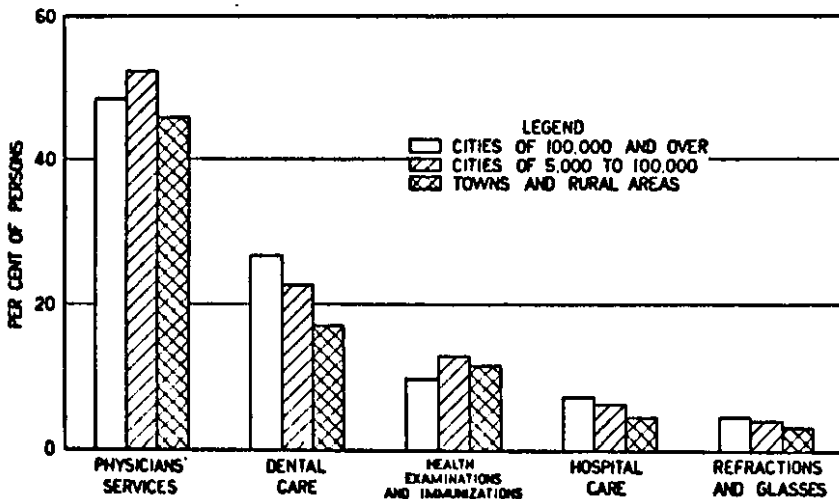


FIG. 4. THE RELATION OF SIZE OF COMMUNITY TO THE VOLUME OF MEDICAL CARE

This diagram shows, with two minor exceptions, that as the size of the community decreases the volume of care received decreases.

Based on data showing the percent of persons who received any of the various services specified. These data covered 88,008 white persons in 8,039 families with known incomes surveyed for 12 consecutive months, 1928-1931.

The responsibility for variations in charges, therefore, is a broad one arising from variations in the costs of all four of the principal types of service. If the uncertainty of medical costs is to be largely eradicated for all or nearly all families, the uncertainty for every one of these types of service must be eradicated. Insurance for any one type of service will each year eliminate much of the variation for *some* families; but insurance for all types is necessary to eliminate all or nearly all the variation for *every* family.

Professional and Institutional Incomes.—Medical costs which are too high for many families do not necessarily mean high incomes for practitioners. Although it is impossible to pass definite judgment upon the adequacy of the average professional net income of physicians in private practice (\$5,300 in 1929), it is clear that income is much less evenly distributed in medicine than in several comparable professions, and that the actual incomes are inadequate for a large number of practitioners and more than adequate for some others. The extent of this maldistribution is suggested by the wide interval between the middle or median net income of \$3,800 and the average of \$5,300. Furthermore, in 1929 one-third of all private practitioners had net incomes of less than \$2,500. For every physician with a professional net income of more than \$10,000, there were two who received less than \$2,500. The contrast is especially great between general practitioners and specialists. In 1929, the 70,000 general practitioners as a group received less income than the 30,000 complete specialists. The average net income of the former group was under \$4,000, while that of the latter was over \$10,000. Physicians' incomes vary widely according to the size of the communities in which they practice. Forty-four per cent of the private practitioners, for example, practice in communities of 100,000 population or over, and their total incomes constitute 54 per cent of the total for all physicians. In communities of 5,000 to 100,000 are 26 per cent of the physicians, and they receive 28 per cent of the total income. In the remaining small towns and rural areas are 30 per cent of the physicians, and they receive but 18 per cent of the total income.¹⁶ In other words, the average income of the rural practitioners is less than one-half as large as the average for the metropolitan physicians. Dental incomes show a similar distribution. *Certainly no solution to the problem of medical costs can be reached through a reduction in the average of professional incomes.*

The difference between gross and net incomes is considerable. The average gross income of all physicians in 1929 was \$9,000. Approximately 40 per cent of this income goes for professional expenses, such as office rent, maintenance and replacement of equipment, salaries and wages of nursing and office personnel, transportation, and other items. This large over-

head of private practice adds to the cost of care to the patient, without financial return to the practitioner. This overhead, furthermore, must be paid from collections which in "good times" are on the average about 10 to 20 per cent below the amount charged.

Furthermore physicians generally feel under obligation to give "free work." While it is impossible to estimate the volume of free service with accuracy, there can be no doubt that its money value is significant. There is some controversy as to

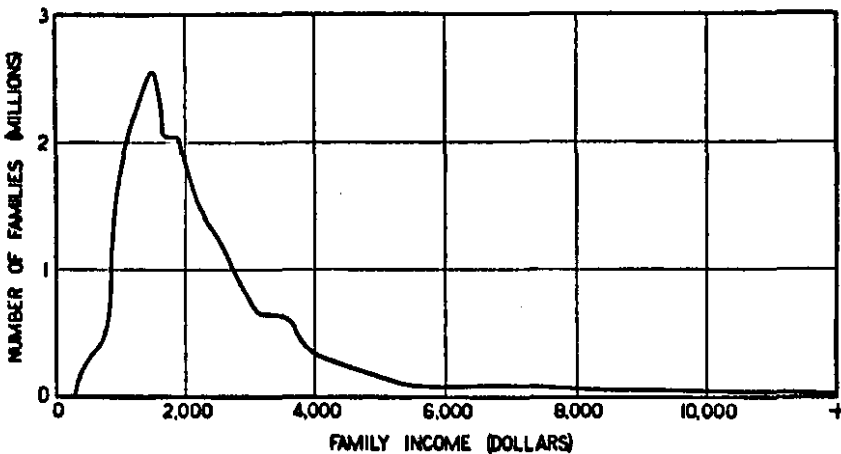


FIG. 5. THE DISTRIBUTION OF FAMILY INCOME

This diagram shows that a preponderance of families in the United States receive annual incomes considerably under \$2,000 and that a very small percentage receive incomes of \$4,000 and over.

Based on estimated percentage distribution of the total income of the United States among families of two or more persons, 1928. Estimated from the distribution of individual income recipients.

who pays for free service. Some physicians contend that it is their contribution to charity. Another view is that the physician is remunerated by the added experience and the added prestige of hospital and clinic connections, which justify him in charging higher fees to his pay patients. But there are a large number of physicians who have few or no well-to-do patients to whom they can pass on the cost of free work. To them it is a burden from which they have little opportunity to escape." Even were this not true, the institution of free work would be socially objectionable as a method of distributing the cost of free service, since it would assess this cost on only a section of the well-to-do—those who happen to fall ill. The

cost of free care at present is either an unjustified burden on the physician or an unjustified burden on those of the well-to-do who seek his services.

The precariousness of the incomes of a large majority of physicians, dentists, and other professional personnel is another serious social problem. The professional net incomes of physicians in communities of less than 5,000 population, for example, decreased from 1929 to 1930 by approximately 10 per cent in the Middle Atlantic states, 19 per cent in the New England and Pacific states, and 50 per cent in the West South Central states (Oklahoma, Texas, Arkansas, and Louisiana). The average reduction for physicians in all areas was 17 per cent. In 1931 and 1932 still further declines were suffered.¹⁸ When practitioners' incomes drop, they do so in part because the people are not purchasing even the customary amount of service, and in part because the physician is being asked to carry individually the community's burden of charitable medical service.* The Committee believes that, from the social point of view, neither of these conditions should be tolerated.

One of the worst results of the present method of remunerating physicians is that practitioners may have, or may be thought to have, an economic incentive to create unnecessary medical service or to prolong illness. It is one of the glories of medicine that so few physicians and dentists, placed in this anomalous position, yield to the temptation. But it is well-known that some do yield and that, as a consequence, some medical cases are prolonged needlessly, some unnecessary operations are performed, and some necessary operations are performed by surgeons who are selected because of the size of the rebate which they will secretly give to the referring family practitioner. "Fee-splitting," although strongly condemned by the medical profession, has arisen in part because of the unjust difference in many cases between the fee of a general practitioner or internist and the fee of a specialist. While fee-splitting tends to overcome this inequality, it increases the costs of professional care, degrades the profession, and, in effect, puts the patient in the hands of the highest bidder. Furthermore, it weakens the incentive for skillful and careful work on the part of the specialist.

* A small part of the recent decrease may also be due to an actual decrease in illness and a larger part, perhaps, to the change in price level.

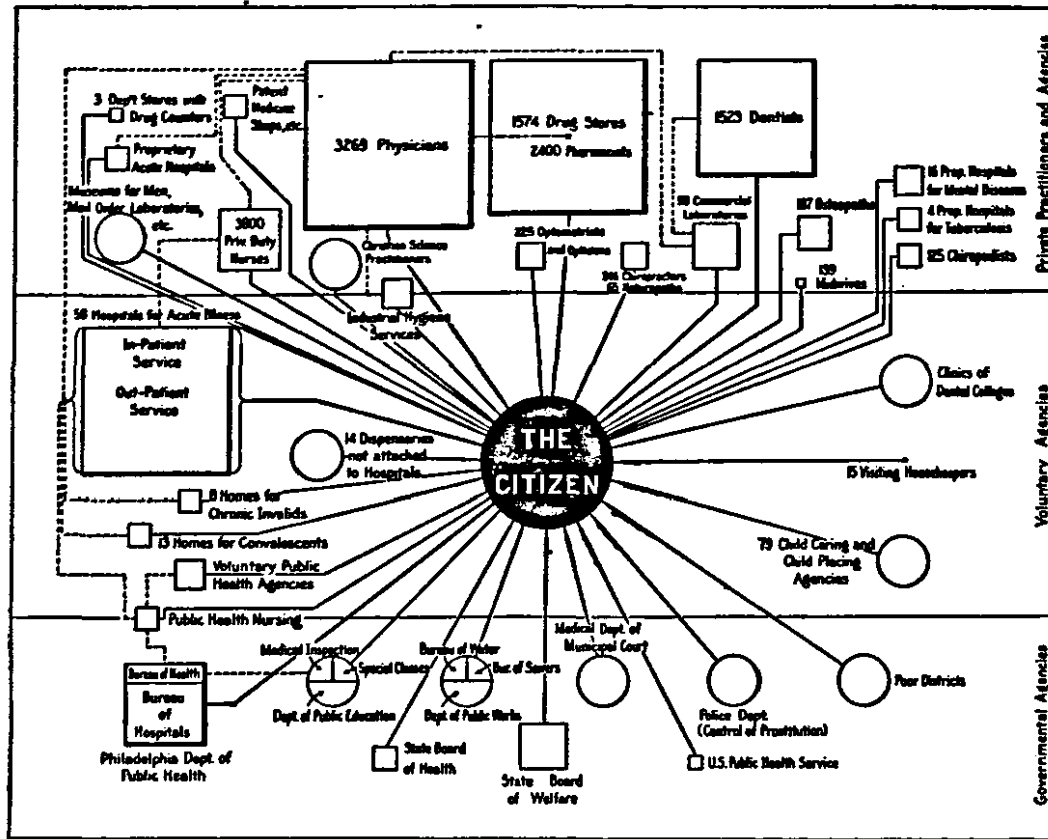


FIG. 6. THE COMPLEXITY OF MEDICAL CARE

This diagram shows the complex network of medical facilities in a large city. Many of the significant interrelations could not be depicted here. The area of each square indicates the relative costs to the citizens of Philadelphia in 1928 of various types of medical care. For items indicated by circles, data are unavailable.

Another distressing problem is the extensive and increasing unemployment and under-employment among private-duty nurses. Nursing education has been provided at little direct cost to either nurses or the public. Because of the general belief that it was economical for hospitals to operate training schools, and the hopes of women for an increased earning power, nurses have been trained in ever-increasing numbers regardless of the demand for their services. Furthermore, the quality of nursing education varies widely. As a result of these two factors, the profession is greatly overcrowded, some nurses are poorly trained, and employment for the competent as well as the unfit is neither stable nor adequate. Conditions were bad even before the present economic depression. For many competent nurses, the situation is now desperate.

Many hospitals are finding it increasingly difficult to balance their budgets without seriously impairing their efficiency. Except on the Atlantic seaboard, hospitals are customarily expected to be nearly or entirely self-supporting. On the other hand, the community rightly insists that hospitals should keep up-to-date in equipment and facilities, and at the same time should not raise charges to a point which works hardship. The non-governmental hospitals face a crisis. In 1927, an average of only 65 per cent of their beds were occupied and by 1931 the percentage had dropped to 62. Requests for free service have increased. Income from private philanthropy and community funds has been seriously reduced. Hospitals are not able to pass on any appreciable percentage of the costs of free work to well-to-do patients. Expenses cannot be reduced enough to meet these difficulties without impairment of service. As a result of these factors there is serious question whether the voluntary hospital system in American can survive.¹⁹ Governmental hospitals have increased in number, in quality of service, and in the proportion of beds occupied. They, however, customarily do not serve the very people who, through taxes, contribute most to their support.

Capital Investment in Medical Practice.—The physician now needs for private practice a larger professional equipment than formerly and must spend more money and time on his medical education. These requirements make it difficult for the young physician to get under way effectively. Furthermore, the development of hospital work, from a service which 50 years ago

was limited in its medical scope and utilized almost entirely by the poor, into a general community enterprise providing service for nearly all major illnesses, has necessitated an enormous capital investment. Over \$3,500,000,000 has been invested in land, buildings, equipment, and endowment of hospitals and clinics in the United States. Of this investment, over 90 per cent has been provided, on a non-profit basis, from government funds or from philanthropic individuals and organizations,

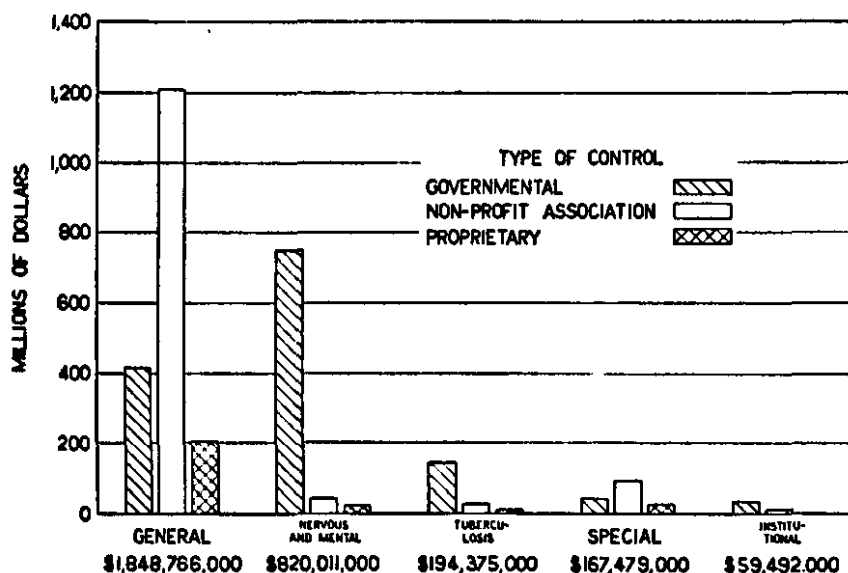


FIG. 7. THE CAPITAL INVESTED IN THE NATION'S HOSPITALS

This diagram (based upon data for 6,852 "registered" hospitals in 1928) shows that, while much of the capital for general hospitals comes from governmental sources, most of it comes from non-profit associations. In the case of nervous and mental, and of tuberculosis hospitals, however, nearly all the capital comes from governmental sources.

without expectation of financial return. The total capital invested in equipment for medical and dental service is estimated at about \$5,850,000,000, of which \$900,000,000 is the investment by physicians and dentists in their professional equipment and in hospitals owned by physicians, \$3,550,000,000 is the investment made by the public without expectation of return and the balance represents investments in commercial buildings and equipment rented to physicians or dentists for office or laboratory purposes.²⁰

An increasing proportion of medical service, therefore, is

rendered by practitioners who use a capital investment provided by the public for the benefit of the public. The typical American hospital or clinic is essentially a partnership, or working understanding, between a group of physicians who provide the professional service, and are organized as a staff for the direction and control of the professional work, and a group of lay persons representing a voluntary organization or a government department, having the legal ownership of the capital and carrying the financial responsibility. This expanding partnership between the professions and the public is one of the most significant aspects of medical practice. If this relationship is to progress on a sound basis, it will be necessary to develop adequate cost-finding, accounting, reporting, and other techniques borrowed from industry.

Provision of Drugs and Medicines.—The American people spend annually about \$715,000,000 for drugs and medicines, most of which they purchase directly from retail druggists or general merchants. The sales of drugs and medicines compare in magnitude with the total earnings of physicians or hospitals. These sales greatly exceed the annual expenditures for dentistry, private duty nursing, or public health. These expenditures, however, have not aroused the same complaints as have the costs of physicians' services and of hospitalization. The reasons are that the expenditures for medicines are more fully predictable as to time and amount, are relatively uniform among individuals, are frequently avoidable in part or in total and, above all, are made in small amounts.

Although manufacturers and vendors of drugs and medicines are, in many respects, engaged in the healing arts, they are not restricted in their business relationships with the public to the codes of ethics customarily followed by physicians in professional practice. Nor do the Federal and state food and drug laws require disclosure of the formulas of medicines, except those regulated by the prohibition laws, the narcotic laws, or the poison laws.

Less than one-third of the drugs and medicines consumed annually are used on the express order of physicians, even when allowance is made for drugs utilized in physicians' offices and in hospitals.

There are 132,000 trained pharmacists authorized to compound the medicines prescribed by licensed practitioners. The

pharmacists of the country, on the average, compound only about 1,200 prescriptions per year, although a well trained pharmacist could prepare ten times this number without sacrificing professional standards or lowering the quality of the product.

The development of the drug store into a department store for many commodities has made the services of pharmacists readily available to the people without unduly high costs for prescribed medicines. But it has surely not retarded the growth of sales of secret-formula medicines, purchased by the patient for a self-diagnosed disease or condition. The annual sales of such "patent medicines" amount to \$360,000,000, most of which is money wasted. This is ten per cent of the total spent for all medical services and commodities.

Complexity of Medical Practice.—Medical facilities and medical practice, except in some small communities, are growing increasingly complex, and, therefore, confusing to the patient. A considerable proportion of physicians, amounting in some communities to 80 per cent, limit their practice to a specialty, and almost as many more tend toward specialization. Some twenty-five different specialties of medicine are recognized. The great increase in the number of persons living in large cities and the increased mobility of the population through modern methods of transportation are among the social factors which have decreased the frequency of continuous personal contact between individual families and physicians. Many individual families, particularly in urban areas, find it difficult to discover a satisfactory family physician, and often unwisely choose specialists without the guidance of a general practitioner. There is a wide-spread public demand for usable information. The increased proportion of illnesses cared for in hospitals forces many patients to choose between home and hospital, a choice which they are not always in a position to make wisely. Many persons are confused by these and other complexities of medical practice.

Organization in Medical Service.—In one sense of the word, the medical professions are highly organized. Physicians, dentists, and nurses have fully developed local, state, and national societies, and these exercise an immense and wholesome influence upon standards of training and practice. Many local and national organizations of specialists stimulate both scien-

tific and practical advances. About two-thirds of the 142,000 physicians of the United States are members of their county medical societies and thus of the state associations and the American Medical Association. These organized medical groups are of the first importance as expressing professional standards and opinion, and they play major parts in representing the profession in its relations with educational, industrial, philanthropic, public health, and governmental bodies.

A different type of organization of medical service has also developed in the United States. About two-thirds of all physicians of the country are now associated with hospitals or clinics. National professional bodies have furnished significant leadership in working out hospital staff organization and procedures which contribute to the efficient care of the patient and to effective relationships among staff physicians.

On the other hand, in many ways the growing complexity of medical service has outrun the development of its organization. The fact that medical care may now be obtained through an increasing variety of practitioners and agencies tends to create a lack of continuity in the medical care of the individual. During the course of a single year, he may receive from several different specialists services which are not coordinated by a family physician. If he goes to a hospital, he may pass under the care of a physician who was not previously acquainted with his case; and on his discharge from the hospital, the information concerning his hospital diagnosis and treatment may not be available for the physician or clinic which becomes responsible for his subsequent care.

The provision of medical care is also unorganized from the point of view of the community as a whole. The educational facilities of a community, on the contrary, are planned and distributed on the basis of the number of children of various ages. The community's expenditures for education are budgeted, and the relative merits of expenditures for buildings, for equipment, and for teaching staff are discussed and agreed upon. A definite attempt is made to eliminate waste and to maintain standards. Increasingly, building programs for public schools are planned for five, ten, or fifteen years in the future, and this is true not only in metropolitan areas but also in smaller cities and in rural areas. The various persons and agencies concerned—school boards, superintendents, teachers,

special consultants—are organized to promote effectively their common efforts in a common task.

There are differences between education and medical service which should be taken into account. The analogy is useful, however, to show that, although medical service is as essential to the national welfare as public education, the task of providing it to all the people has not yet been tackled in an organized and coordinated way.

Cost of Complete Medical Care.—If services were organized economically and efficiently and sold to representative groups of the population, among whom there is not an abnormally high rate of sickness, all needed medical care of the kind which people customarily purchase individually could be provided, in urban areas at least, at a cost, excluding capital charges, of \$20 to \$40 per capita per annum. Included in this care would be the services of physicians, dentists, and other personnel, and the provision of hospitalization, laboratory service, x-ray, drugs, eye-glasses, appliances, and other items. This estimate of cost is based not only upon a theoretical computation of the amount of service necessary to meet the people's real needs and the cost of providing it,²¹ but also upon the experience of various organizations that are now providing complete or nearly complete service for weekly or monthly fees or without direct charge to the beneficiary.²² The following figures show the range of these annual per capita costs, excluding hospital capital charges which are usually not met from patient's fees:

Cost of Adequate Medical Care—Based on Lee-Jones Estimate.....	\$36.00*
Family population of Ft. Benning, Georgia.....	30.00†
(Incomplete dentistry; exclusive of eye-glasses)	
Endicott-Johnson employees and their dependents.....	21.02
Roanoke Rapids employees and their dependents.....	17.46
(No dentistry; exclusive of drugs and eye-glasses)	
University of California students.....	14.59
(Selected population—9 months only)	
Employees of Homestake Mining Company and their dependents.....	12.48
(No dentistry or home nursing)	
Families subscribing to Ross-Loos medical service.....	10.84
(No dentistry or nursing; exclusive of eye-glasses)	

On the whole, the services provided at these places are of good quality, although not in every instance the best that could be asked or that could be obtained if larger funds were avail-

* Excluding public health service and the costs of hospital care for patients with mental disease or tuberculosis. These costs are also omitted from the other figures.

† Exclusive of costs which are due to the military character of this organization and which normally would not be experienced by a civilian population.

able. At Fort Benning, the care is of exceptionally high quality and wide range, including unlimited hospitalization and the services of all ordinary specialists; only dentistry appears inadequate. Both in scope and volume of service and in cost, this organization supplies medical care which approximates the requirements of "good medical care."

Each of these organizations provides its patients with a substantially larger volume of services than most persons receive for approximately the same expenditures. This is made possible (1) by the organization of the services so that the time of practitioners is conserved and the medical facilities are used efficiently, and (2) by the provision of service on such financial terms that patients are encouraged to obtain care in the early stages of illness, thus probably reducing somewhat the number of difficult cases.

Low-income families, however, usually cannot pay an annual cost of even \$20 to \$40 per capita. A family of five with an income of \$1,500, for example, would have to spend \$100 to \$200, or 7 to 13 per cent of its income, to pay for such service. Anyone familiar with the budgets of families in this income group knows that such an expenditure for medical service would entail severe hardship. As was shown above, however, an annual cost of \$30 per capita is well within the *collective* resources of the country. Even a cost of \$40 per capita would have constituted in 1929 less than 6 per cent of the *total* money income of the country. Unless the national income increases so rapidly that many of the families at the lower end of the economic scale are enabled, on a periodic payment basis, to meet such costs, some method of tapping the combined resources of the population must be found.

The Needs Which Should be Met.—To focus attention on those problems which called the Committee into being, there are listed below the deficiencies in the provision of medical service which seem to be within the power of the American people—professional and lay, separately or together—to overcome at the present stage of medical knowledge. These needs may be stated briefly as follows:

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

b. Modern public health services need to be extended to a far

greater percentage of the people, particularly in rural areas, towns, and small cities.

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

d. In the rural and semi-rural areas, the current expenditures for medical care are insufficient to insure even approximately adequate service, to support necessary facilities, or to provide satisfactory remuneration to the practitioners.

e. There should be an opportunity for many practitioners to earn larger net incomes than they now receive. This is particularly true of well-trained recent graduates, who frequently must practice for five to ten years before they attain an adequate income. The incomes of general practitioners and of specialists should be more nearly equal than at present, and the opportunity and incentive for "fee-splitting" should be removed.

f. There needs to be better control over the quality of medical service, and opportunities should be provided for improving quality as rapidly in the future as it has been improved in the past. Practice by unqualified "cult" practitioners should be eliminated, and control should be exercised over the practice of secondary practitioners, such as midwives, chiropodists, and optometrists. The practice of specialties should be restricted to those with special training and ability; more opportunity for postgraduate study should be available for physicians, particularly rural practitioners; and there should be constant chances for physicians to exchange experiences and assist each other. The work of certain physicians and dentists, who even though they are regularly licensed are nevertheless not competent for many functions, should be closely controlled and improved through supervision and further education.

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

h. There is a need for reduction of waste in many different directions. Substantial sums are wasted on unnecessary medication, on the services of poorly qualified or utterly unqualified "cultists," in the idle time of physicians, dentists, nurses, and

other practitioners, in the high "overhead" of private medical and dental practice, in unused hospital accommodations, and in the time of patients who go from place to place seeking medical service.

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

In view of the widespread waste and planlessness of effort and expenditure, it is amazing that so much is done. Physical facilities are duplicated between the hospitals and the offices of practitioners and are insufficiently utilized in both. Hospital beds are empty and much of the physician's, dentist's, and nurse's time is idle while many persons suffer and many die for lack of medical attendance. Misdirected expenditures, competition and excessive specialization among practitioners, and the absence of community planning and of integration of services and facilities contribute to extensive waste.

Responsibility for Present Situation.—The present methods of providing medical services; of paying for them; of utilizing assistant personnel; of financing, constructing, and operating hospitals; of carrying out public health activities; of educating practitioners; in short, the whole group of arrangements and devices through which the body of medical knowledge is translated into service is a result of generations of growth. No one person and no one group of persons planned the present conditions or can be held responsible for them. They are not the creation of practitioners alone, but of practitioners, patients, hospital trustees and superintendents, health officers, educators, philanthropists, industrial employees and employers, and government officials.

From a larger point of view, medicine is to a considerable extent dependent upon the whole social fabric into which it is woven. The social attitudes, the habits of mind, the cultural standards, the economic activities, the monetary returns, and the spending habits of the people all affect the practice of

medicine. The widespread adoption of old-age pensions, of unemployment reserves, of long-term economic planning or of other social changes now being discussed would influence medical activities. Some of the questions which most disturb the profession have their roots deep in the soil of American habits, traditions, and culture.

This fact does not mean, however, that medicine is irrevocably tied to present devices. Social conditions are constantly changing and medicine will change with them. Many developments in medical practice can be effected without waiting for social changes. The pattern of society merely sets the ultimate limits; it does not determine the immediate steps.

This survey leads the Committee to one general conclusion. The one million persons who furnish medical care and the one hundred and twenty-three millions who may receive it should make concerted and carefully planned efforts to meet needs and to devise remedies for present deficiencies and wastes.

The present situation is a result of growth in the science of medicine, in the arts and organization of practice, and in the changing structure and attitudes of our urbanized and mobile civilization. Medical care is essential. While it requires substantial expenditures, its absence or inadequacy involves still greater costs. The organized professions of medicine, dentistry, pharmacy, and nursing; the organizations of employees and of employers, the civic, social welfare, and governmental agencies all have a stake in this great problem and ample reasons for bending energies towards its solution. None of the major problems of medical care can be solved by any one group alone. Those who furnish the services on the one side and those who receive and pay for them on the other, must cooperate if either is to meet the needs which they perceive or to attain the benefits which they desire.

REFERENCE NOTES TO CHAPTER I

NOTE: Much of the factual data in this chapter has been taken from the Summary Volume (Publication No. 27 listed at the end of this report) without specific reference. Reports listed below by publication number are documents published by the Committee.

1. Publication No. 3, p. 23.
2. J. S. Chambers and Harry R. Lynn, *Medical Service in Kentucky* (University of Kentucky, Lexington, 1931); Publication No. 3; Summary Volume Chapters V, VI, XI and XII.
3. Publication No. 22.
4. Dr. Frederick H. Allen, quoted in *Ohio State Medical Journal*, May, 1931, Volume XXVII, p. 404.
5. *Preliminary Committee Reports, White House Conference on Child Health and Protection* (Century Company, New York, 1931), p. 512.
6. Louis I. Dublin, *The Annals of the American Academy of Political and Social Science*, November, 1928.
7. Thomas Parran, Jr., "Syphilis from the Epidemiologist's Point of View," *American Journal of Public Health and the Nation's Health*, February, 1932, Volume XXII, p. 141-156.
8. James A. Crabtree and E. L. Bishop, "Syphilis in a Rural Negro Population in Tennessee," *American Journal of Public Health and the Nation's Health*, February, 1932, Volume XXII, p. 157-164.
9. Publication No. 23.
10. Summary Volume, Chapter IV.
11. *Health Protection for the Pre-school Child, A National Survey of the Use of Preventive Medical and Dental Service for Children Under Six* (Century Company, New York, 1931), p. 512.
12. Publication No. 25 and Summary Volume, Chapter II.
13. Publication No. 26 and Summary Volume, Chapter V.
14. Publication No. 24, Table 14.
15. Publication No. 26, Chapter XIV.
16. Publication No. 24.
17. Publication No. 24.
18. Publication No. 24.
19. Michael M. Davis and C. Rufus Rorem, *The Crisis in Hospital Finance* (University of Chicago Press, Chicago, 1932), Chapter I.
20. *Op. cit.*, p. 66-67.
21. Based on data from Publication No. 22.
22. Publications Nos. 5, 18, 19, 20, 21 and Miscellaneous Contributions No. 13.

CHAPTER II

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CHAPTER II

THE ESSENTIALS OF A SATISFACTORY MEDICAL PROGRAM

Many of the problems discussed in the previous chapter have long engaged the attention of practitioners and laymen. A multitude of plans and experiments have been brought forward to solve some or all of them. These plans and experiments present an almost infinite variation in completeness, in quality, in the treatment accorded to practitioners, and in cost. In evaluating any experiment or in formulating a plan for the provision of medical service, it will be useful to have a clear statement of the essentials or criteria by which soundness and effectiveness may be judged. There appear to be six basic essentials as follows:

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

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

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

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

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

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

When, hereafter, the Committee speaks of a "satisfactory medical service," it means a service which meets these six essentials.

* The term "public health program" is meant to include the work of the official health departments and of voluntary health agencies.

Each of these essentials will now be briefly considered; an ideal embodiment of them will be suggested in Chapter III and specific recommendations presented in Chapter V.

THE SIX ESSENTIALS

1. Safeguarding Quality of Medical Service and Personal Relation.—No plan is economically sound which does not safeguard quality, since efficient service is in the long run the most economical. Any plan, therefore, should be judged primarily by the effect it will have upon the quality of medical service. If it necessitates hurried or impersonal work, if it does not permit physicians and other practitioners to keep up-to-date through postgraduate study and contact with their fellows, if it develops an antagonistic relation between physicians and patients so that the golden element of confidence is lacking, if it sets up devices that put the practitioner's economic and his professional interests in conflict, or if it isolates certain practitioners from necessary association with others, these defects must be corrected or the plan condemned.

The preservation of a personal relation between patient and physician is an essential element in safeguarding the quality of medical practice. This relation, as the Committee defines it, includes "not only the privileged confidential communications of patient to physician which are recognized as inviolate by law, but also the relation involved in the communication of his medical history to any physician chosen by the patient and *the continuing mutual responsibility between patient and physician*. This in no way inhibits the patient from giving his confidence to different physicians or to the medical integrator of a group of physicians. The business relation between physician and patient is not considered a necessary part of the personal relation as defined above nor does the definition carry a commitment for or against any scheme of organization of medicine."

Medical care, by its very nature, is and must remain a distinctly personal service. Although the personal element is relatively less significant in some specialties or special services, it should always be considered. Man is not a standardized machine and each individual reacts to the conditions of life in

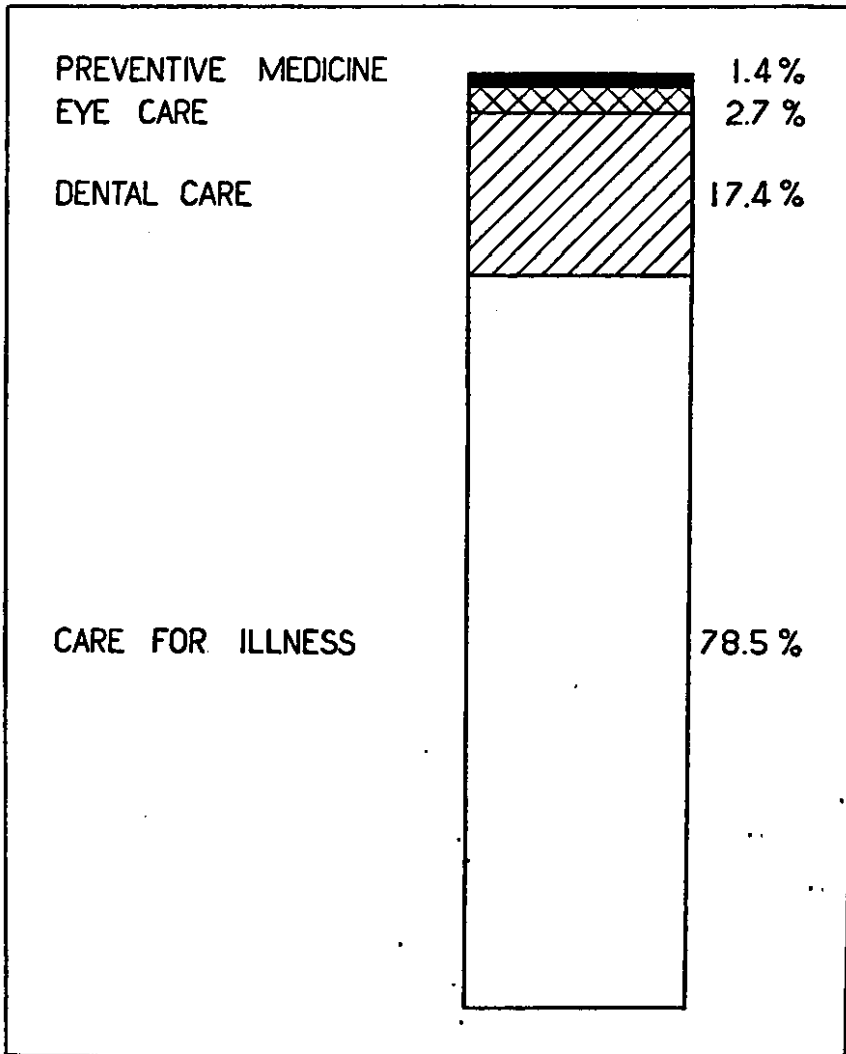


FIG. 8. FAMILY EXPENDITURES FOR THE PREVENTION AND CARE OF ILLNESS

This diagram shows that most of the money spent directly by the people for medical care goes for the treatment of illness, and a very small proportion is spent for prevention, even when the care of the teeth and the eyes is included.

Based upon the charges incurred by 8,689 families surveyed for 12 consecutive months, 1928-1931. These figures are weighted averages for all income classes.

a manner, in some respects, unique. To make an accurate diagnosis and to adapt treatment to these individual variations, the physician himself must see his patient and see him, in many cases, over an extended period of time. The physician needs continued contacts and study to enable him to treat the patient as a human being in a family and a social environment and not merely as a complex of symptoms. The choice of the patient should determine the selection of the physician. Most significant of all, the physician must have the opportunity to establish himself as the trusted adviser and confidant of the patient on all matters affecting health. Confidence is frequently more important than drugs.

There is nothing in any way mysterious in the relation between a physician and his patient. On the therapeutic side it is capable of completely objective analysis. As to those phases which are not strictly medical, it is of a piece with all satisfactory human relations involving as they do mutual patience, sympathy, understanding, and confidence.

Under present conditions, the old-time relation with a family physician is often disturbed, partly because the family physician may not have maintained an adequate standard of knowledge and skill, and partly because confusing relations have arisen with independent specialists, clinics, and hospitals. The family physician should be restored to his place of responsibility and trust and his potentialities extended by substituting coordinated for uncoordinated relations with specialists and the other agencies which permit him to do his work effectively.

2. Provision for Meeting the People's Real Needs.—A concerted attempt should now be made in the United States, with consideration of economic and geographical variations, to supply *all* the people's needs for *good* medical service. The amount of care which people need is far greater than that which they are aware of needing, and greater than that for which they are able to pay under present conditions.* In view of the lethargy and active opposition usually encountered in effecting changes, however desirable, it may not be practicable to supply all the people's needs at once, but any plan to be satisfac-

* For a discussion of the data on this point see Chapter I and Summary Volume, Parts II and III.

tory must provide for the continuous development of its component services until eventually they cover all the needs of all the people.

3. Provision of Service on Acceptable Terms.—If adequate services are available but can be obtained only on financial terms which a large number of persons cannot or will not meet, the problem is not solved. Most communities, in officially assuming at least a theoretical responsibility for the care of indigents, have already taken the position that no human being should be allowed to suffer, on account of poverty, from remediable illness or distress. Our present system, however, on the one hand lays an unjustifiable burden of unpaid service upon the physician and the hospital and, on the other hand, frequently gives the individual of the middle economic level only a choice between becoming a recipient of charity or foregoing needed medical care. A satisfactory program should make it possible for a large proportion of the total population to pay in full whatever may be charged for needed medical service, on terms which are reasonable and which fully preserve self-respect. The cost of care for those who cannot pay should be distributed, according to ability to pay, over the rest of the community.

4. Emphasis on Prevention.—Medical service should include systematic and intensive use of preventive measures in private practice and in public health work. The cost of adequate *therapeutic* treatment, already considerable, probably will increase with further developments in medical technology. Through the prevention of disease further increases in the total cost of medical service can best be avoided. Moreover, physical and mental suffering, and other personal and social costs which cannot be measured in monetary terms, are often caused by diseases which might be prevented. For these reasons any program for the provision of medical service should have as its paramount aim the *prevention* of disease.

Preventive service to patients and instruction and guidance in the basic principles of personal hygiene should form an increasing part of the work of the individual physician, whether in his office, in the patient's home, or in the hospital; and organization, both of service and of payment for service, should be such as to facilitate the widest application of preventive medicine.

Public health services should be adequately supported. All parts of the country should be provided with the basic public health activities, namely: (a) the collection of vital statistics; (b) the control of the water, milk, and food supplies; (c) the control of sanitation; (d) the control of communicable diseases, especially tuberculosis and venereal diseases; (e) the provision of laboratory service; (f) popular health instruction; (g) the promotion of maternal, infant, and child hygiene, including school health service; and (h) the organization of other special services when needed for the prevention and treatment of malaria, hookworm or other diseases which constitute special health problems. Popular health education should be carried on by schools as well as by health departments and medical practitioners. These developments require better financial support for public health work and a trained personnel, with tenure dependent only upon technical and administrative competence.

5. Selection of Competent Practitioners.—The physician is the first "contact man" between medical science and the people. He occupies the front-line trenches in man's warfare with disease. It is vital, therefore, that he be competent and qualified for his work. Since medical service is a "commodity" the value of which the patient cannot correctly judge, it is important that he be assisted in the selection of practitioners and facilities.

6. Adequate Payment to Practitioners and Agencies.—A major essential of a satisfactory medical service is the provision of adequate compensation to physicians, dentists, nurses, and other scientific practitioners, and adequate support to hospitals and other agencies. The training required of those who render service is long, costly, and arduous, and their responsibilities are exacting. They should be paid accordingly.

All practitioners should receive sufficient compensation and the conditions under which they work should be such as to make certain that high-grade men and women will continue to be attracted to these professions and will find it possible whole-heartedly to devote their time and attention to their professional work. Many hospitals and health agencies likewise need a more nearly adequate and stable basis of support. The necessary money should come either from the individual patient

directly or from some central fund to which he has contributed all or part of the amount needed for his care.

GENERAL LINES OF APPROACH

In order to obtain such a satisfactory medical service, three major lines of approach are needed:

a. The development of types of organized or group practice that will more effectively and economically meet the community's medical needs.

b. The distribution, over a period of time and over a group of families or individuals, of the costs of service.

c. Provision for the planning and coordination, on a local and regional basis, of all health and medical services.

Provision of Service Through Organized Groups.—Most physicians and dentists are independent practitioners who deal directly with their patients. The individual responsibility of each practitioner for the quality of service which he renders must be retained to assure good professional care.

During the last two or three decades, however, various developments in medicine have made it increasingly important that service be coordinated and organized. The first and most important development is the rapid advance in medical art and knowledge and the growing necessity for specialization and a division of labor. No man can now master all medical knowledge and develop all the skilled techniques. Not only have specialties developed, therefore, in medicine itself, but numerous related or subsidiary professions and technical occupations have arisen. Many patients now go directly to independent specialists without first consulting a general practitioner. This practice increases the complexity and the cost of medical service and tends to relegate the family physician to an unimportant place.

A second development is the increase in the capital investment required for the study, diagnosis, and treatment of disease. Many of the practitioners who work alone are unable to afford the costly and varied equipment necessary for diagnosing and treating all illnesses; nor do they have the time to become proficient in its use. The well-qualified general practitioner can indeed care for a large proportion of illnesses, but to realize his ideal possibilities in many cases he needs

association with specialists and access to the facilities furnished in a good hospital.

A solution for these difficulties lies in the organization of general practitioners and specialists into groups for achieving the benefits of closer professional relations and economical use of equipment and assistant personnel. The Committee's studies have described examples of group practice which demonstrate that certain advantages can be realized. It is obviously more economical to provide hospital facilities and scientific equipment to a group of physicians practicing cooperatively than to the same number of doctors in independent work. Competent management, of both the business and the professional aspects of practice, and adequate organization and direction of subsidiary personnel can be assured more readily to a group. Group practice can be made to stimulate professional improvement through the provision of adequate equipment and of sufficient time for study and postgraduate work, and above all, through the mutual criticisms of colleagues. Younger men will be stimulated by the knowledge that advancement depends upon the sober judgment of professional seniors rather than the relatively uninformed choices of the laity. Through the stimuli of daily cooperative work, group practice tends to break down the separatist habits of thought and action which beset the specialist, and also to create a form of organization which makes a place, but no more than its due place, for each specialty. Group practice may materially assist in bringing specialists into proper relation with one another and with general medical service. The form in which group practice is organized is very important, although no form of organization can rise above the level of the men and women who participate in it.

On the other hand, group practice may perpetuate some of the defects of individual practice and, in fact, may create new difficulties if the type of organization is faulty, or if the responsible individuals are not suited to their tasks. The principal dangers of group practice are: (1) The medical group may become so large that not only the patients but even some of the practitioners are treated as mere cogs in a machine and the personal relation is lost; (2) some practitioners may lose their individual initiative and energy if their existence is assured by the group; and (3) the desires of older men to keep

their grip on power and the ambitions of younger men to attain it can be more effectively destructive within an organization than they can between independent competitors.

Standards for Group Practice.—To avoid these possible dangers and to realize fully the advantages of group practice, principles or standards should be formulated by a joint commission appointed by appropriate professional associations. The most important of such standards are:

(a) *General Medical Care.*—The professional group should give general medical care as well as specialist service and

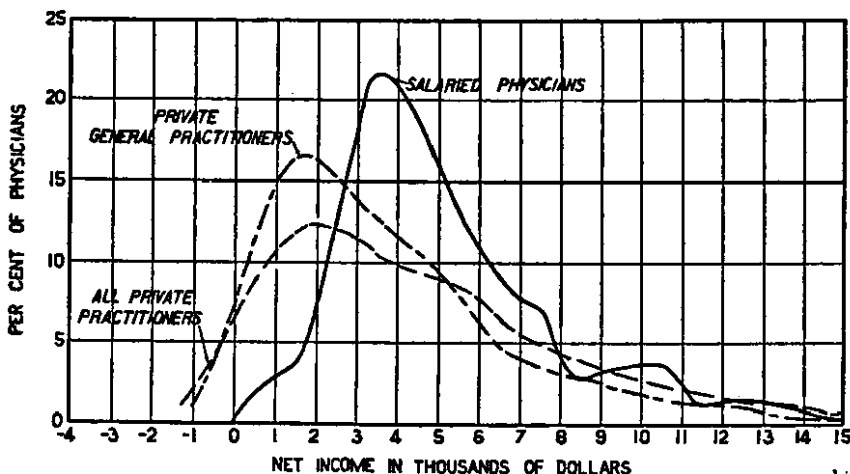


FIG. 9. THE NET INCOMES OF PHYSICIANS

This diagram (based upon studies of the incomes of about 13,000 physicians) shows that the most frequent net income of salaried physicians is higher than that of private practitioners.

should include a due proportion of physicians with the training and point of view of the general practitioner.* This does not preclude the reception of some patients for specialist or consultation service.

(b) *Coordinated Diagnosis and Treatment.*—The members

* Although theoretically a "general practitioner" performs all the various services done by physicians, in actual practice this is rarely true except in rural areas. Practically all general practitioners in cities and towns exclude one or more of the major fields of medicine. General practitioners who affiliate with groups would usually change very little the medical fields in which they would practice. That there is an important place for general practitioners in organized medical services is clearly shown by the Committee's studies of such organizations. The term "family practitioner" is frequently used in these pages to mean the physician in a group who handles, in the first instance at least, all or the major part of the calls from his group of patients and who maintains the personal relation with patients.

of the professional group should coordinate their service and pool their knowledge so as to give each patient the best diagnosis and treatment possible.

(c) *Individual Responsibility.*—The group should hold some particular physician responsible for the care rendered to each patient. This physician should be chosen by the patient or chosen for him at his request. It should be this physician's duty to interpret the findings made by any other physicians consulted. Continuity of relationship, year after year, between the patient and the physician should be strongly encouraged.

(d) *Promotion of High Standards.*—Systematic procedures should be carried on by the group for the professional stimulation of members and the maintenance of high standards of work.

(e) *Association With a Hospital.*—Whenever possible, the group should be associated with a hospital, often constituting its professional staff and, preferably, having offices in or adjacent to the hospital building. In any event, the same group of doctors should be responsible for the care of patients in office, home, and hospital.

(f) *Professional and Lay Participation.*—Where groups associate with a voluntary or governmental hospital, the board of trustees of the hospital will usually continue to carry the financial responsibility and exercise general administrative supervision. The professional group, however, should have definite control over professional policies and procedures and full opportunity to discuss with the lay group those problems in which professional and administrative questions are intermingled.

(g) *Non-Profit Character.*—The danger which physicians and dentists principally fear, namely that lay groups organized for profit will control medical practice, is a real one. Such groups, they believe, will place the practitioners in subservient positions, will deny them proper equipment and professional opportunities, or in other ways will prevent them from rendering service of a high quality or from receiving adequate compensation. Such groups add to the cost of service without contributing any essential element which cannot be provided equally well by non-profit professional or community groups. It is far better for the organizing activity, the capital investment, and the assumption of financial risk to come from non-

profit community, religious or governmental hospitals or similar agencies. The Committee believes that *lay groups organized for profit have no legitimate place in the provision of this vital public service.*

Distribution of Costs.—Extensive studies of the incidence of illness and the expenditures for medical care have been made by the Committee and cooperating agencies. No conclusion has emerged more consistently than this: The costs of medical care are felt as a burden more because they are unevenly distributed among the people than because of their total amount. This unevenness was discussed in Chapter I. That some families of moderate means spend substantial sums on “luxuries,” yet are not able in times of sickness to meet the costs of medical care, is beside the point so long as the medical costs are met on an individual fee-for-service basis. The cost of luxuries can be planned in advance or met in installments; the cost of illness for the individual family cannot. On a group basis, however, both the incidence of illness and the probable cost of its care can now be predicted with reasonable accuracy.

Inevitably the Committee has been led to the conclusion that the costs of medical care should be distributed over groups of people and over periods of time. There are two major methods of distributing costs: insurance and taxation. Both these methods are now in use but not sufficiently to prevent these costs from being a burden to most persons and impossible to many. Both methods can be and are applied, either to meeting the costs of certain forms of medical care, or to meeting the costs of all forms of care for certain groups. Extension of either method, therefore, may be effected by widening the scope of the medical services, by increasing the population group covered, or by a combination of these two procedures.

Definition of certain terms at this point and discussion of certain general issues will clarify the recommendations of the Committee which are given in Chapter V.

Insurance.—The Committee defines insurance as a procedure by which a group of persons pay uniform sums of money to meet the costs of medical care. The principle of insurance is universally familiar as applied to fire, death, accidents, and

many other risks. In connection with illness there are two financial risks: (a) the costs of medical care, and (b) the loss of income during illness and of future net earnings in the case of death. The problem of this Committee relates only to medical care, but reference to the problem of wage-loss is necessary.

Wage-Loss and Cash Benefits.—Extensive experience in this country and abroad has shown that the wage-earning population evinces more interest in financial protection against loss of

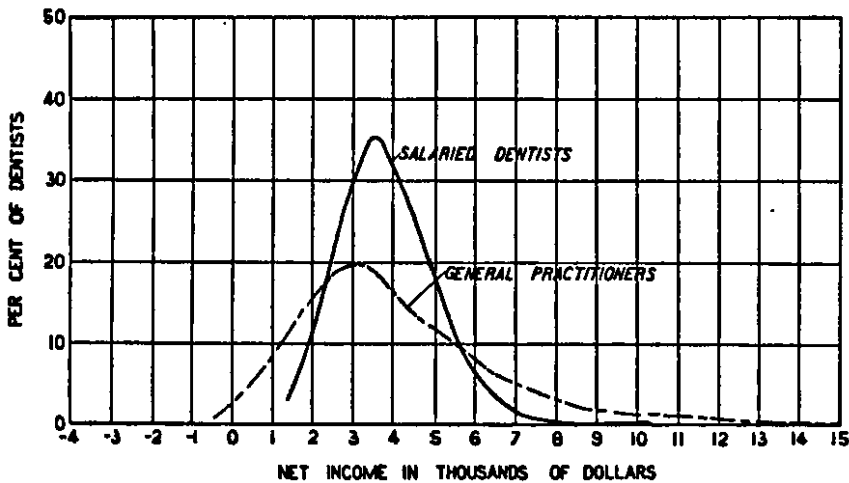


FIG. 10. THE NET INCOMES OF DENTISTS

This diagram (based upon a study of the incomes of 5,493 dentists) shows that, in 1929, the most frequent net income of salaried dentists was higher than that of dentists in general private practice. Fewer of the salaried dentists received either very small or very large incomes.

income due to illness than in the provision of medical care. If there are no savings, complete stoppage of income because of the illness of a wage-earner immediately threatens the whole family with destitution. All foreign systems of health insurance which have developed on a large scale have met this wide-spread demand by including provision, not only for medical care, but also for cash benefits to meet a part of the wage-loss.

The studies available to the Committee have made clear that serious difficulties arise when the administration of cash benefits is united with the provision of medical care. The amount of

cash paid in any case necessarily depends upon a medical certification of the existence and degree of disability. It is to the interest of the insured *group* as a whole to keep cash benefits down, whereas the insured *individual* naturally wishes a generous benefit in his particular case. Physicians who endeavor to serve these two interests simultaneously find it difficult to do so, and at the same time fulfill their primary professional responsibility for adequate diagnosis and treatment. In several foreign systems of health insurance, this has been a major source of controversy, ineffectiveness, and sometimes of heightened costs. The demand for income protection during illness, however, must be met for large numbers of wage earners, and the problem of medical certification is inherent and must be dealt with so as to minimize the difficulties. Recommendations as to methods of meeting the need for income protection lie outside the scope of the Committee's work, but it here emphasizes its sense of the importance of this need. It insists, however, that there shall be a clear-cut separation between insurance to meet the costs of medical care and insurance to cover a portion of the wage loss due to illness.

Undoubtedly the difficulties over medical certification have been due in part to hasty or incomplete examination of the patient and to failure to keep good clinical records. Plans of insurance for medical service, developed as such, with high standards of professional service to patients, would provide a foundation from which the medical problems of cash benefit could be more successfully met. The specific recommendations made by the Committee in a later chapter are framed with this policy in mind.

Insurance Companies.—The participation by commercial insurance companies in the forms of insurance against the costs of medical care which are recommended in this report would, the Committee believes, tend to increase the costs and not to improve the quality of service. Each member of a group of insured persons, who contributes to a common fund from which the costs of medical care are met, has an incentive to reduce malingering and unnecessary illness costs. This incentive to efficiency and economy is liable to be lost if sick persons can throw financial responsibility upon an insurance company. Furthermore, the arrangements will be more satisfactory to all

parties if, in financial matters, the practitioners can deal directly with patients or their representatives, than if they must deal only through an intermediate business agency. Administration by private insurance companies would largely, if not entirely, forfeit the most important element in the establishment and maintenance of quality, namely: effective professional participation in the formulation of policies.

Workmen's Compensation and Industrial Medical Services.— In almost all our states, both the wage-loss caused by industrial accidents and the provision of medical care has been made a financial responsibility of industry. This is, broadly speaking, a form of social insurance of limited scope. In some states, certain diseases which are regarded as occupational have also been included.

It has been suggested that this system might be extended to cover diseases in general. In the opinion of the Committee, it would not be advantageous to extend the principle of workmen's compensation in this way, since it would place the whole financial responsibility on the industry and would make employees and their physicians more directly dependent on employers. Moreover, periods of unemployment would then mean suspension of this provision of medical care. From the standpoint of industry, the financial objections are also serious. The employer, it is true, has a stake in the physical efficiency of his employees and may appropriately contribute to their medical care; but it is neither socially desirable nor financially practicable for the employer to assume full responsibility for such care.

In some of the organized medical services reported in the Committee's studies, the employees of an industrial plant obtain and largely pay for general medical service through a health insurance scheme, while preventive medical care and care for industrial accidents are furnished by the same group of physicians, at the expense of the employer. Such interrelations are obviously desirable, but, as in these organizations, the respective financial responsibilities of employers and employees should be clearly defined.

Although the Committee believes that the full cost of general medical service is not a proper responsibility of employers, industries may properly cooperate with their employee

groups in insurance schemes by furnishing administrative conveniences, or by supplementing the payments of employees, or in both ways. The employment of individual physicians, however, directly by the owners of an industry, for furnishing general medical care to employees often places the physicians in a position where they find it difficult to maintain satisfactory standards of work. Employees themselves are then the ultimate sufferers.

Taxation.—Tax funds now meet about 14 per cent of the nation's annual medical bill. Most of the hospital care of persons with mental disease, or with tuberculosis and other communicable diseases, and all work of health departments are maintained by taxation. The same is true of the care of military and naval personnel, of inmates of prisons and other wards of the state, and is theoretically true of general medical care of so-called "indigent" persons. These are accepted forms of "state medicine," a term which the Committee uses to cover the provision of medical care by the government. It should be observed, however, that the mere use of tax funds as a means of paying certain costs of medical service does not of itself constitute "state medicine," since some tax funds pay for medical service which is administered in voluntary hospitals or by individual physicians in private practice.

The major present tax outlay for medical care is for hospital service. The capital investment in governmental hospitals was estimated for 1928 at over \$1,400,000,000; the operating costs of 1930 as \$303,000,000, or about 46 per cent of the total operating costs of all hospitals. Of the \$303,000,000, about \$185,000,000 was for hospital care of mental disease and tuberculosis, and the remainder, \$118,000,000, for general hospital service. More than half of the general hospital care is provided by cities and counties through local hospitals. A few states provide general hospital service directly and some furnish subsidies to local institutions. Such general hospital service as is furnished by the federal government is for special groups only—veterans, soldiers, sailors, and inmates of certain institutions. There is substantial agreement that it is proper to use tax funds to provide organized preventive work and care of certain diseases, namely: those, like tuberculosis, which are a

menace to the community, and those, like mental disease, which can be adequately cared for in no other way.

Taxation is peculiarly necessary where there are wide divergences in the financial resources of different localities, and where the tax is levied by the state or some unit larger than the locality. Medical needs arise, roughly speaking, in proportion to the size of the population, but the ability to pay is in proportion to resources. In many of our states are areas wherein local financial resources do not and cannot meet the cost of satisfactory medical care. Occasionally privately financed "demonstrations" have enabled such places to establish or improve hospital or health services. Only local tax funds, aided by state tax funds, however, are a sufficiently large and stable source of support to enable such areas to obtain a satisfactory medical service. In fact in certain areas, Federal aid may also be necessary. The Committee believes that the primary responsibility is local but that where local funds are insufficient supplementary aid should be given from, preferably, the next larger governmental unit.

Planning and Coordination of Service.—In all but very small communities the complexity of present day medical services is often baffling to the public and to the practitioners themselves. Over three billion dollars has been invested on a non-profit basis in the nation's hospital system by local community groups, by religious, racial, industrial, and fraternal organizations, and by governmental bodies. Even when each individual hospital in a locality is efficiently administered, wastes and inefficiencies often exist in the hospital system of the community as a whole. These are largely due to the failure to coordinate institutions, and to the lack of any planned development whereby the amount of investment, and the location and distribution of hospitals, would be determined in view of known present needs and careful estimates of future requirements. The increasing number and variety of specialists, and the uneven geographical distribution of practitioners and agencies have been previously discussed.

There should, therefore, be an agency in each community through which the lay and the professional groups concerned in providing and financing medical services could consult, plan, and act in behalf of the best provision of medical resources which the community can afford. To a limited extent and as

yet in only a few communities, local health and hospital councils have performed this function. Physicians and other professional groups especially concerned should be adequately represented in these coordinating bodies. Those concerned with providing funds should also be represented and should give careful attention to the needs of planning and coordination.

Coordination is especially needed in metropolitan areas. Here some of the problems are regional. There are, for instance, sections in every great city where poverty and inconvenience of location combine to render medical service inadequate or inaccessible, although in the city as a whole there is a plentitude of facilities and personnel. The principal problem is not geographical but functional, namely: to break down the institutionalism of agencies and the sectionalism of groups which waste effort and money and leave some areas uncovered.

To a certain extent the city or county health department is the representative of the public in dealing with such matters. But, without the counsel and advice of a community organization, few health officers or boards of health could wisely solve the broad questions which would face a coordinating body. Whether the health department should take leadership in forming or directing an organization dealing with these problems must be determined by local conditions. The participation of the department in some degree would be essential.

The need of coordination is perhaps most obvious in sparsely settled areas. Only as their low financial resources can be supplemented by funds from more prosperous sections, and only as their limited professional personnel can be stimulated or increased by linkage with physicians and hospitals of other communities, can these sections acquire or retain the needed physicians, dentists, hospitals, and public health officials. If these areas are to continue to be inhabited, policies must be worked out whereby they will be enabled through advice, supplementary funds, or both, to furnish a necessary minimum of service to their inhabitants. This geographical coordination and regional planning may be assisted by the local coordinating agencies described above, but it is primarily the responsibility of a larger area, usually the state.

The state is also the natural body to insist that medical organizations meet reasonable minimum standards of quality in their medical services. The standards themselves should be

formulated by national or state professional bodies, as suggested previously in the discussion of organization. But such bodies are usually not in a position to insist on observance of their standards, nor is the control of community agencies necessarily among their proper functions. The public must be protected from inferior medical service, and the professional personnel from exploitation. A state coordinating board would be a logical body to enforce these minimum standards.

Local coordinating agencies must rely primarily upon education and persuasion rather than authority. Their work will usually be done mainly through systematic conferences nourished by a steady supply of facts. The study of data on facilities and needs furnishes a sound basis for joint thinking and cooperative action. Coordinating bodies should strive for better mutual understanding and practical cooperation between the professional groups that furnish service and the lay groups that receive and finance it. There are countless examples of the effective joint participation of medical and lay groups in the hospitals and clinics of this country; of physicians, dentists, and lay groups in local health programs; and of nurses and lay bodies in public health nursing associations. Any broad coordinative plan will encourage these measures and in particular will emphasize the responsibility of the professional groups which are in a position to give continuous attention to the problems of medical care.

State coordinating bodies probably will need more actual financial and legislative authority to meet the more difficult problems with which they will be confronted.

These, then, are the essentials of a satisfactory medical service and the basic lines of approach. Many different programs may be developed, under a variety of auspices, which meet all these essentials, at least in substantial part. Some of the plans which the Committee suggests in Chapter V satisfy some but not all of these essentials. As a temporary expedient, a community may adopt such a program. But if satisfactory medical service is its aim, it must replace or amplify the program until it fully meets these essentials. In Chapter III the Committee outlines one of many possible plans for satisfactory medical service.

CHAPTER III

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CHAPTER III

AN ULTIMATE OBJECTIVE IN THE ORGANIZATION OF MEDICINE

There is a growing conviction that social evolution may be guided wisely and that it is statesmanlike to formulate the objectives of such evolution. What is true of society is true of medical service, for as long as society is on the march, medical service will inevitably be on the march, too, and should have a clear vision of the goal ahead. The Committee, therefore, presents its conception of an adequate type of medical organization and an effective method of paying for medical service. This should be the major objective during the next twenty-five years of communities which seek to solve the problem of providing satisfactory medical service.

The data in Chapter I show that many persons are obtaining inadequate medical care at rates which for them are excessive, and that many persons who give this care are receiving inadequate compensation. A remedy lies in the organization of producers and consumers. Organization in the field of medical care may come through private initiative or through the initiative of the government. That such organization will come seems inevitable. Whether it comes through governmental or non-governmental agencies depends more upon the initiative of the professions and organizations involved than on any other one influence. There are undoubtedly parts of the country where governmental initiative is the only solution. The kind of organization outlined in this chapter constitutes an objective for either governmental or non-governmental effort.

This objective embodies the best features of many existing plans, and avoids so far as possible their disadvantages and limitations. It is not, furthermore, an unattainable goal. The Committee's analysis of the fundamentals of good medical care indicates that the provision of a satisfactory service for all the people requires slight, if any, increases in the numbers of physicians and nurses,* and somewhat larger increases in the

* To those familiar with present employment problems among nurses, it may seem almost fantastic to suggest that even a slight increase in the number of nurses is necessary to provide adequate medical service to all. Yet reasonable standards of adequate nursing require far more service than is at present provided and somewhat more service than the present group of nurses could provide if all were fully employed. (See Publication 23.) The problem is primarily an

number of dentists and other practitioners. A substantial part of the increased cost of supporting a satisfactory medical service could be met by the elimination of wastes in present expenditures. The net increase in cost would not necessarily be large.

THE ORGANIZATION OF SERVICES

The basic advance in achieving the objective here outlined is the provision of medical service by cohesively organized groups of the various scientific practitioners and agencies in the medical field working under a common direction and with a common purpose. Different types of organization are presented for cities, towns, and rural areas in order to take account of their differences in economic and social conditions.

Medical Service in Cities.—The keystone of the concept of a satisfactory medical service for the nation is the development of one or more non-profit "community medical centers" in nearly every city of approximately 15,000 population or more.

This center would include a well-equipped general hospital, an out-patient department, and a pharmacy. It would provide offices for physicians, dentists, technicians, and subsidiary personnel, and headquarters for nurses. All facilities necessary for the practice of modern scientific medicine would be available, such as X-ray, laboratory and physiotherapy equipment, and a well-stocked library. In large communities there would doubtless be several medical centers. The number of persons served by each center might vary widely and each might have branches at various convenient places. In communities with only one center, the headquarters of the voluntary health agencies, of the medical, dental, and nursing societies, and perhaps of the public health department might be located there.

Complete medical service, except, perhaps, the care of tuberculous, mental, and other cases of an institutional type, would be offered by the center. Its physicians would see patients in their homes, at the offices of the center, and in the hospital. Home nursing would be available on a visit, a part-time, or

economic one, although its solution is also dependent upon the production of suitably trained nurses who will be adaptable to changing conditions. This requires a clarification of the aims of nursing education. (See Recommendation 5D of Chapter V.)

a full-time basis, according to the patients' needs. Attendant nursing, including housekeeper service, would be provided. Nursing in the hospital would be sufficient to care for all hospital patients. Medical social service would be available when needed. Adequate institutional provision would be made, perhaps in nearby suburban or rural territory, for the care of convalescent and chronic patients. If chronic patients were sent to other institutions, specific arrangements would be made to maintain contact with the practitioners providing care. Drugs, dressings, splints, orthopedic appliances, crutches, and eye glasses would be supplied and an ambulance service maintained.

Preventive medicine would receive special emphasis. Full use would be made of periodic medical examinations, during which special efforts would be made to discover tuberculosis, venereal disease, cancer or diabetes. In fact every effort would be made to discover disease of all types in its early stages and to limit its development. Smallpox vaccinations and diphtheria or typhoid immunizations would be provided. Insofar as possible, physical defects would be remedied. Mental hygiene would be considered essential, and each family practitioner would be prepared to deal promptly with minor mental disturbances and to refer more serious cases to specialists. Health instruction would be offered regularly through conferences, addresses, instruction by visiting nurses, and printed material.

Not only would special efforts be made, in routine examinations and other contacts, to discover tuberculosis and venereal diseases in early stages, but adequate and continuous treatment would then be given, with the aim of eliminating tuberculosis entirely from among the center's patients and reducing to a minimum the incidence and duration of venereal disease. Furthermore, special health instruction would be given to tuberculous and venereal patients to assist them to care for themselves and avoid infecting others. To all school children under its care, the center would provide adequate medical examinations and all necessary medical, dental, and nursing service. Finally, the center would make earnest efforts to reduce the maternal and infant mortality rates of the groups served to the lowest possible level.

Such an organization might function successfully under

various kinds of administrative control. In each center a special board, similar to the boards of voluntary hospitals but more widely representative of the community, would direct the general policies and assume responsibility for the finances. Whether this board would be an outgrowth of existing self-perpetuating hospital boards, the method now preferred in most communities, or would be chosen by various community groups, elected by popular vote like school boards, or appointed by municipal or county officials is relatively immaterial, so long as the members are interested, competent, devoted to the general good, and free from political interference. The method of selecting the board would naturally depend, in part, upon whether a governmental or non-governmental hospital forms the nucleus of the medical center. The financial and administrative direction of the center would be the responsibility of a well-trained executive, experienced in hospital and clinic administration, and with a broad social background and a firm grasp of social as well as administrative problems. Inter-center competition would be minimized, as will be suggested later, through local and state coordinating boards.

Professional aspects of the service would be under the control of the professional personnel of the center. Through an elected or appointed executive committee or chief of medical, dental, or nursing service, the professional personnel would have the right to nominate members of the staff; to nominate persons for promotion, retirement, or removal; and, subject to approval by the board and director, to control all matters primarily professional. In short, the responsibility for the quality of service rendered by physicians, dentists, nurses, and other practitioners in the center, would rest primarily upon the staff, and the staff would have authority commensurate with its responsibility.

All or nearly all practicing physicians and dentists of the areas served would eventually be on the staff of the single center in a small city, or the several centers in a metropolis. A few physicians and dentists and perhaps a considerable number of pharmacists would undoubtedly prefer to continue indefinitely in individual practice. If there were an oversupply of practitioners, the state coordinating board (to be described later) would assist the surplus personnel in finding locations where their services were needed and where they could earn

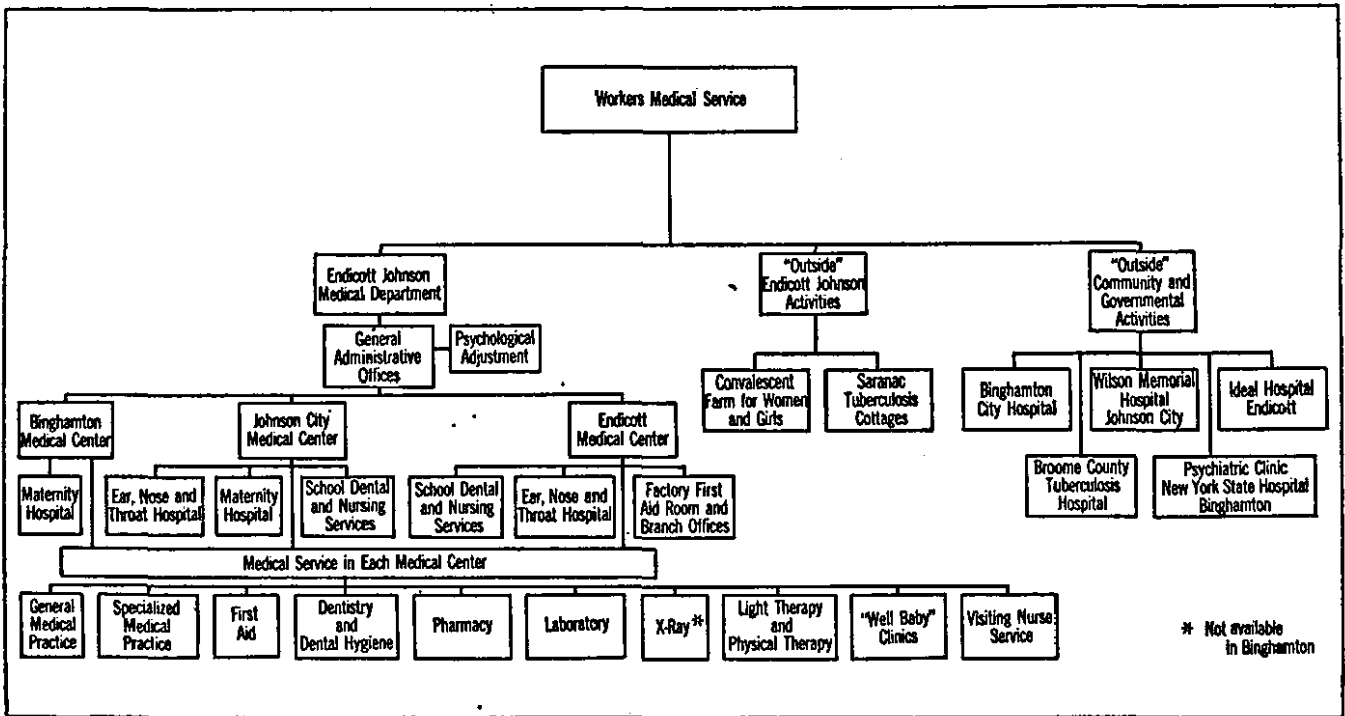


FIG. 11. THE ORGANIZATION OF THE ENDICOTT JOHNSON WORKERS' MEDICAL SERVICE, SHOWING FACILITIES AND ACTIVITIES IN 1928

reasonable returns. The personnel of the center would be remunerated on a salary basis, on a capitation or fee basis, or by a proportional division of receipts. Some method combining several of these bases might prove satisfactory.* Certain specialists might serve as consultants to several centers on monthly retainer fees. Whatever the basis of remuneration, the total funds available for compensation of the professional personnel would be divided, as far as possible, according to each practitioner's competence and responsibilities, as determined by the board of trustees, the director, and the chief-of-service or the executive committee of the staff, and be sufficient to attract to the staff, for the major positions, the ablest men in the community. Definite arrangements would be made for vacations, for leaves-of-absence for postgraduate work, and, as the finances permitted, for retirement allowances.

Within the medical center, the rôle of the family practitioner † would be prominent and respected. For such practitioners the center would choose men with special aptitudes and training, with wide general knowledge of medicine and some insight into psychology and social conditions. Some of the family practitioners might be among the best paid men on the staff. Each patient would be primarily under the charge of the family practitioner of his choice, provided the latter was not already fully burdened, and might at his option change to one of the other physicians.‡ Every effort would be made to maintain or build up that personal relation between the patient and his physician which is an essential part of the best medical service.§ The patient would look to his physician for guidance and counsel on health matters and ordinarily would receive attention from specialists only when referred to them

* *Additional Statement by Committee Members.*—We believe that a salary basis for compensating practitioners would be the best, since it would free the practitioner from the possible temptations to over-treatment or under-treatment which are inherent in a fee system or a capitation system, respectively.—Morris L. Cooke, Mrs. Walter McNab Miller, Alfred Owra, William J. Schieffelin, Walter R. Steiner, John Sundwall, C.-E. A. Winalow.

† See footnote, Chapter II, p. 46.

‡ Provision should also be made for patients at their option to change to another center if one is available. Thus the patient's opportunity for choosing physicians would be substantially as great as it is now.

§ For a discussion of the importance of this relation see Chapter II, p. 39-41.

by his physician. The group would hold this physician responsible for providing adequate preventive and therapeutic medical care, either through his own services or through reference of the patient to his colleagues. Obscure cases would be referred to the man most skilled in diagnosis who, in cooperation with the family practitioner, would plan the examinations and, perhaps, the treatment.

The 45 per cent of the American people who live in "metropolitan areas" of 100,000 population or over, and the additional 7 per cent who live in cities of 15,000 to 100,000 population * would be served by such centers or their city branches.† People in the surrounding areas, within perhaps 10 to 20 miles of the central city, would also be served by the metropolitan medical centers and branches. Thus, at least 50 to 60 per cent of the population would be in direct touch with a center which provided the very best that modern medicine could offer.

Medical Service in Towns and Rural Areas.—In towns of 2,500 to 15,000 which are not part of metropolitan areas, there are about 10 per cent of the population. Since most of these places are too small to support separate full-sized community medical centers, several places would combine where feasible to support a complete center. Where this is not possible, a smaller unit would be established. An existing hospital might be remodeled or a small hospital built, a few physicians, dentists, and nurses employed, a pharmacy provided, and sufficient other facilities made available to care for the majority of medical cases. This unit would be organized as an "affiliated branch" of a fully-equipped center in the nearest city. Difficult or obscure cases would be sent for diagnosis or treatment to the center, or specialists would be called from the center.‡ Many of the branches would be supervised by a medical center, though some would have a large degree of local autonomy.

For the villages and distinctly rural areas, which contain about 38 per cent of the population, a series of "medical sta-

* Exclusive of those in "metropolitan areas."

† The assumption that it would require at least 15,000 persons to support a complete medical center is somewhat arbitrary and subject to honest difference of opinion. For a discussion of the question see footnote in Chapter IV, p. 79.

‡ An arrangement embodying some of the relations between branches and medical centers here proposed has been effected between the New England Medical Center in Boston and the Rumford (Maine) Community Hospital. It is described by Dr. Joseph H. Pratt in the *Bulletin of the American Medical Association* for June, 1932.

tions" would be strategically located. Each station would be under the supervision of a complete medical center or an affiliated branch, and would consist of one or two physicians, a dentist, and a few public health nurses or trained nurse-midwives.* These stations would rely upon affiliated branches or medical centers for facilities or services which the station personnel could not supply. Occasionally travelling specialists would visit the medical stations to treat special diseases. Through the linkage of medical stations to affiliated branches and of affiliated branches to community medical centers, the entire population would be provided with complete, adequate, supervised medical service; yet a large degree of autonomy and responsibility would be retained locally.

Existing Bases for Organization.—The development of medical centers, branches, and stations can and should come as a natural evolution of existing organizations in the medical field. At the present time governmental and non-governmental general hospitals are available for community use in approximately two-thirds of the counties in the United States. Over 116,000 of the 142,000 active physicians of the country are now associated with these hospitals on regular, courtesy, or visiting staffs or as superintendents, internes, or resident physicians. Nearly 1,000 hospitals provide offices where physicians may see private ambulatory patients. At present, 4,500 physicians have such privileges.

In nearly all hospitals there is at least a minimum of staff organization. Financial arrangements between the hospital and its staff are increasing in number, and the staff is assuming a growing responsibility for the quality of the work. In the hospital itself there is already a considerable integration of the functions of various agents—nurses, laboratory and x-ray technicians, dietitians, physiotherapists, pharmacists, maids, orderlies, and janitors—although much further progress in this direction is needed. These hospitals furnish the most convenient foundations on which to build community medical centers, and much of the necessary capital has already been invested in them. Somewhat different, but also highly useful, foundations are furnished by the 200 private group clinics in the United States.

* If nurse-midwives are used, they should be trained to do public health nursing. For a description of nurse-midwives who provide such service see Chapter IV, p. 67-68.

The system sketched above is obviously too detailed to be applied *in toto* and without adaptation to any particular community. It should be useful, however, as a guide to communities which are planning to provide satisfactory medical service.

COORDINATION AND CONTROL OF SERVICES

Although community medical centers, affiliated branches and medical stations eventually will provide a large proportion of the medical and health services needed by a community, their development will take years of effort. In the meantime many existing practitioners and agencies will continue to carry on their important services. Furthermore, these proposed medical centers will never supersede or embrace all the existing medical institutions and agencies. Individual private practice, particularly among the well-to-do, may continue indefinitely; public health activities are a permanent governmental responsibility; industrial organizations will continue sanitary and preventive services to employees; and governmental provision of hospitalization for tuberculous and mental patients will probably increase. Some of the unofficial public health agencies may continue their independent existence indefinitely. The work of medical centers should be coordinated with the work of all other agencies.

In each self-contained local area, therefore, whether a city, a county, or a group of counties, there would be a local coordinating body to examine critically and to coordinate the preventive and therapeutic medical services of the community, to limit undesirable or unnecessary medical activities, and to stimulate the provision of additional services as needed. For the larger problems which extend across municipal and county boundaries, a state-wide agency is needed. The composition and methods of work of local and state coordinating agencies were discussed in Chapter II. In addition to the functions outlined in Chapter II, the state coordinating board should supervise the development of medical centers, branches, and stations to prevent unnecessary and uncoordinated building. In its exercise of control, the board should give careful heed to local desires, particularly as expressed through the local

coordinating board, if there is one, and should take into account the fact that for a long time to come, experimentation, especially in local units, will be desirable.

METHODS OF PAYMENT

The cost of the service provided by a medical center, branch, or station would vary in different communities because of differences in (1) the adequacy of existing facilities and the necessary expenditures for new land, buildings, or equipment, (2) the compensation to practitioners, which would depend in part on the costs and standards of living, and (3) the degree to which various refinements of service would be expected and required by patients. Assuming, however, that practitioners are compensated on the average as well as they now are or even somewhat better, and that hospital costs approximate the average in good institutions, the total cost, exclusive of capital charges, of a complete service by community medical centers would fall somewhere between \$20 and \$40 per capita, per annum.*

This cost could be met in one of three ways: (1) by insurance paid for in full by the individuals or families served, with or without assistance from their employers, (2) by the use of tax funds, local, state, or both, or (3) by a combination of insurance and taxation. The first method is the one to be tried first, particularly in urban areas. In some communities it might solve the problem of payment for substantially all the population and should, in those instances, be continued indefinitely. In many communities, however, there are large groups of persons whose incomes are so low that they could not, from their own resources, pay the full cost of satisfactory medical service even on an insurance basis. Although taxation might spread the cost in a fairly equitable manner, it would relieve patients of all direct individual financial responsibility. While this has been a reasonably satisfactory plan for the financing of education, highway development, and certain other community activities, most members of the Committee believe it is not desirable for medical service when other plans are practicable.

* See section on "Cost of Complete Medical Care" in Chapter I, p. 21-22.

The third method, in the opinion of a majority of the Committee, is ultimately the most desirable one for urban areas. Under this plan an average weekly or monthly amount would be ascertained which individuals or families, including even domestic servants and casual laborers, could pay without undue

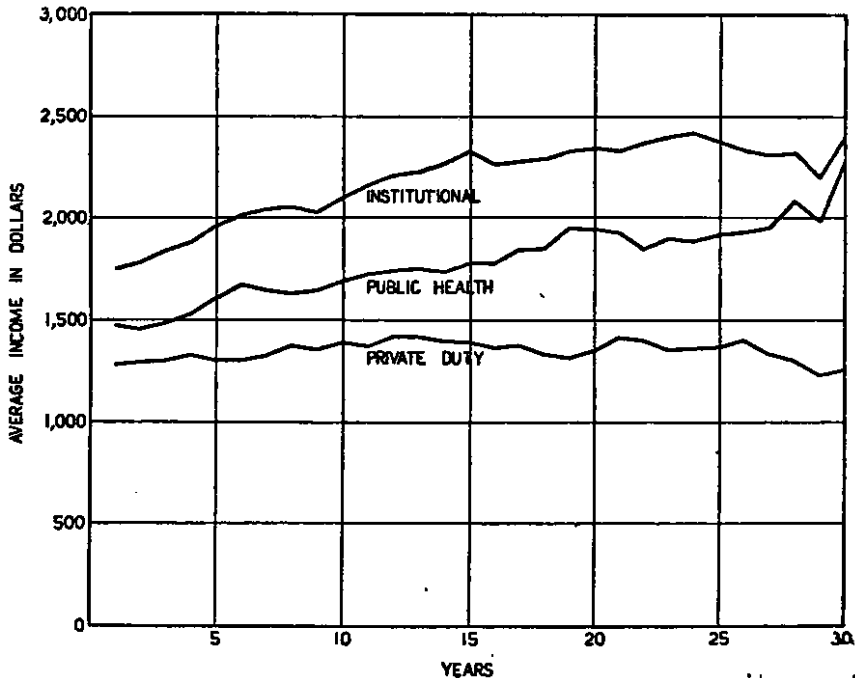


FIG. 12. THE INCOMES OF INSTITUTIONAL, PUBLIC HEALTH, AND PRIVATE DUTY NURSES

This diagram shows that in general the incomes of institutional and public health nurses increase slightly with years of service, but that there is no general increase in the incomes of private duty nurses. It also shows that the average income of public health and institutional nurses is higher than that of private duty nurses.

Based upon data for 1927 obtained from 3,392 private duty nurses, 1,456 public health nurses, and 1,908 institutional nurses. The incomes of institutional nurses include \$500 for maintenance. Adopted from "Nurses, Patients and Pocketbooks" by May Ayres Burgess.

hardship. The balance would be paid by the local government on a per capita or lump sum basis, assisted where necessary by the state or Federal government. This would provide a partial distribution of the costs according to a rough measure of ability to pay, and yet preserve a direct financial responsibility on the part of each patient. A somewhat similar system for the

provision of hospital service as an independent supplement to national health insurance has been rather successful in England.* Each week small sums of money are collected from industrial workers by the employer and from other persons by volunteer collectors. These payments cover most of the cost of ward care for all members of the family who require hospitalization; the balance of the cost is paid from charitable or tax funds.

Some communities might prefer to pay all or substantially all the cost of medical care from the tax levy. In the more sparsely populated rural areas this would be generally the method preferred and sometimes the only method feasible. Whatever method is employed, the important thing is that payment be so arranged that all persons may obtain a satisfactory medical service without undue hardship and that the professional personnel be properly remunerated.

If an insurance plan † is used, either with or without supplementary support from tax-receipts, the question of requiring persons in the low-income groups to subscribe must be faced. The unmistakable trend in European countries has been toward compulsory rather than voluntary insurance. On this question, the Committee has not reached agreement. The differing viewpoints are presented in Chapter V.‡

Since the health insurance here proposed has certain features in common with other insurance activities, the state should require the medical organizations to maintain adequate reserve funds and to conduct their business on an actuarially sound basis.§

* Sir Arthur Newsholme, "International Studies on the Relation between the Private and Official Practice of Medicine, with Special Reference to the Prevention of Disease" (Williams and Wilkins Co., Baltimore, 1931), Volume III, Chapters III and IV.

† For a definition of the term "health insurance" as here used see Chapter II, p. 48. It does not include any cash benefits.

‡ See p. 124 et seq. and 120 et seq.

§ Under the combined insurance and taxation plan the state, it will be observed, would not directly administer any medical service, except public health work, but would have four principal functions: (a) to enforce minimum quantitative and qualitative standards of service which would be formulated by professional bodies, (b) to supervise finances and assure actuarial soundness, (c) to furnish leadership in the planning and coordination of service, and to provide financial assistance where necessary, especially for rural areas, and (d) perhaps, to make health insurance for the low-income groups a requirement. These functions might be allocated to several state boards but preferably they should be centralized in one well directed commission adequately representing the public and the various professions.

It should be pointed out that the health insurance here described differs in three important respects from the types offered in most European countries. In the first place, this system is predicated upon service being provided by organized medical groups rather than by individual practitioners. Many of the difficulties experienced both by patients and by practitioners under European systems * will be avoided, the Committee believes, if service is obtained from well organized groups, since such groups will be far better able to maintain their legitimate interests and their proper and socially desirable professional standards than individual practitioners. Furthermore, economies can be realized in group practice which are impossible in purely individual work. In the second place, this insurance is completely divorced from any system of income protection through cash benefits. Many of the worst abuses of health insurance abroad have arisen because of the desire of insured persons for financial rather than medical assistance. Unquestionably there is a need for income protection, but any system of cash benefits should be separate from the provision of medical service. Finally, the insurance here suggested will pay for a far more nearly adequate medical service than is usually provided abroad. Especially significant is the fact that this medical service includes full use of preventive measures, early care of incipient disease, and preventive and curative dentistry.

It is imperative that all steps toward group organization and especially toward group payment should be so safeguarded as not to threaten directly or indirectly those professional standards which are essential to good medical care. The possible dangers of group organization were discussed in Chapter II. The Committee's recommendation of group practice and group payment is subject to the condition regarding non-profit character discussed on p. 47-48 and to the following additional conditions: (a) that the group be so organized that adequate standards of service, such as those outlined in Chapter II, can and in all probability will be maintained, and (b) that the practitioners be fairly compensated with due regard to their education, responsibilities, and community status.

* For a discussion of health insurance plans in other countries see Chapter IV, p. 96-101.

The system outlined above may well constitute a goal for community effort in the organization of medical service. Some features of it are impractical at the moment because of the present state of mind of the American people and of the professions concerned. Other features are not feasible immediately in the face of existing economic and social conditions. The plan as a whole, however, and all the essential elements in it are within the range of practicability within the next two or three decades.

Attainment of this goal will bring many advantages. First and most important, it will bring to all or nearly all the people a much wider participation in the benefits of modern medical knowledge. There would be little or no occasion for people to deny themselves skilled medical attention because of inability to pay, since even in relatively sparsely populated districts there would be a minimum of good care available and the quality of medical service would be under constant and effective control by professional and governmental agencies. The fact that good medical care would be available at costs which the people could pay would tend to wean patients from poorly trained or substandard practitioners and to discourage self-prescribing and the use of patent medicines. Both the need and the opportunity for "fee-splitting" would disappear.

The majority of practitioners, dentists as well as physicians, would gain through more assured and stable incomes, opportunities for vacations and postgraduate study, openings for young well-trained practitioners, adequate facilities for conducting modern practice, and close association with professional colleagues. They would also benefit from the fact that the supply of practitioners could be more closely adapted to the need for their services. The most difficult problems of nurses—security of income and opportunity for advancement—would be largely solved.

Society as a whole would receive substantial and hitherto unrealized dividends from its investment in medical research and education. With the facilities of the country more effectively utilized, there would be a marked improvement in the health, happiness, and peace of mind of the American people.

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CHAPTER IV

PLANS AND EXPERIMENTS NOW UNDER WAY *

Both practitioners and laymen have long been aware of some of the deficiencies in medical practice set forth in Chapter I. Aside from the traditional methods of medical practice with which all are more or less familiar, a variety of suggested solutions have been tried in various parts of the world. The Committee and cooperating agencies have gathered data on the most significant of these plans and experiments in the United States. Four of them have been sponsored by professional groups and four by consumer groups. The largest number, thirteen, have developed under community groups, some voluntary and some governmental, but with the participation of professional groups. One is sponsored jointly by professional and consumer groups and three by commercial agencies. In addition, the Committee has been provided with the findings of two recent studies of European health insurance organizations. In the succeeding pages, this material is briefly summarized.

A. UNDER PROFESSIONAL SPONSORSHIP

1. **Care of Indigents by County Medical Society.**—In the last few years at least ten county medical societies in Iowa, and a few in other states, have contracted with their local governments to provide medical care to the indigent, *i. e.*, persons officially understood to be recipients of charity, in return for annual payments by the local governments. In Marion County, Iowa, for example, the society was paid \$2,430 for such service in 1932. Care is usually provided by the physicians in their own offices, each one caring for those patients who come to him. The funds are customarily used to pay the physicians' dues to local, state, and national medical associations, and the residue, if any, is pro-rated to the physicians on the basis of their work. In most instances there is no central direction of the work and no systematic division of labor, although in a few counties an organized clinic has been established.¹ †

* Free use has been made in this chapter of material from the Summary Volume (Publication 37), Parts VI and VII. The reader interested in more detailed information is referred to this volume and to the various studies therein summarized.

† The reader will find all the reference notes to this chapter assembled at the end thereof with numbers corresponding to those in the text.

The advantages of this experiment are that it places definite responsibility on the county medical society to care for the indigent, and on the local authorities to pay the physicians, at least in part, for their services. Control over the quality of the service and the division of the compensation is left in the hands of the organized profession.

On the other hand, the service usually is not well-integrated; some practitioners may render more than their fair share of service; and dentistry, nursing, and hospitalization either are not provided at all, or are not closely related to the physicians' work. Moreover, preventive work is not extensive. This development, so far as the Committee knows, has appeared, with one exception, only in small rural communities. The compensation to the physicians, which ranges from \$2.60 to \$10 per patient per year, is usually inadequate.

2. Provision by County Medical Societies of Insurance for High-Cost Illnesses.—A type of insurance for high-cost illness was proposed during the summer and autumn of 1932 by a committee of the Medical Society of Milwaukee County, Wisconsin. It suggested the formation of "The Community Medical Service of Milwaukee," under a joint medical and lay executive board, to enroll individuals and groups of persons who would pay regular monthly dues (based on incomes) in return for designated professional services. These services would be provided by any member of the county medical society who wished to participate in the plan. Subscribers would be allowed "free choice" among the participating physicians and institutions.

It is expected that "indigents" would make no payments of monthly dues, but would receive services from the tax-supported county hospital and dispensary. Sums might be paid from taxes to the Community Service for the work of physicians in the homes of indigent patients. A non-indigent subscriber "when sick, must purchase direct from his doctor, in the usual manner of private practice, his entire medical care up to a certain amount (in any one year) before he is entitled to medical service under this plan." Arrangements could be made for deferred payment for such services. "The amount of medical care to be purchased direct is to be determined in proportion to income."

The net result of the financial arrangements would be to protect the subscriber and his family against the burden of catastrophic illnesses only. Simple illnesses would continue to be paid for on a private fee basis, unless a succession of such cases in a family brought the total expense beyond the specified limit. Preventive services, except those required after the limit has been reached, would not be financed through the regular monthly dues. No provision is made for coordinated work and its probable economies.

3. Joint Use of Professional Personnel and Equipment.—In many cities, groups of 3 to 20 physicians or dentists have reduced their overhead costs through joint utilization of office space, waiting rooms, scientific equipment, and technical and clerical personnel. Instead of referring X-ray procedures and laboratory tests to other practitioners, for example, some such groups pool the expenses of maintaining X-ray and laboratory personnel primarily for their own patients. Some groups jointly employ a lay business manager. Customarily the participants in such a plan maintain separate financial relations with patients and complete professional independence. Often the groups are composed exclusively of specialists. Thus certain economies are effected and physical proximity facilitates consultation and saves the time of patients. Such arrangements do not, however, aid the patient who needs a general practitioner, nor provide a sure method of directing patients to the right physician. Furthermore, there is no effective professional control over the quality of service, nor any assurance that economies will be shared with patients. Such arrangements may be considered as temporary phases of the transition from individual practice to private group practice.

4. Private Group Clinics.—The idea of group practice in medicine has developed rapidly in the United States, particularly since the World War. The distinguishing features of a private group clinic are: (1) its physicians are engaged in the cooperative practice of medicine and use many facilities in common; (2) all or most of the physicians are engaged full-time in clinic work; (3) two or more of the major specialties are represented on the clinic's staff, and an attempt is made to give complete service to all patients who are accepted; (4) the patients, although frequently under the charge of a single physician, are the responsibility of the whole group; (5) the

financial responsibility rests with an employed business manager; (6) the income is "pooled" and the remuneration of practitioners is determined by agreement among the practi-

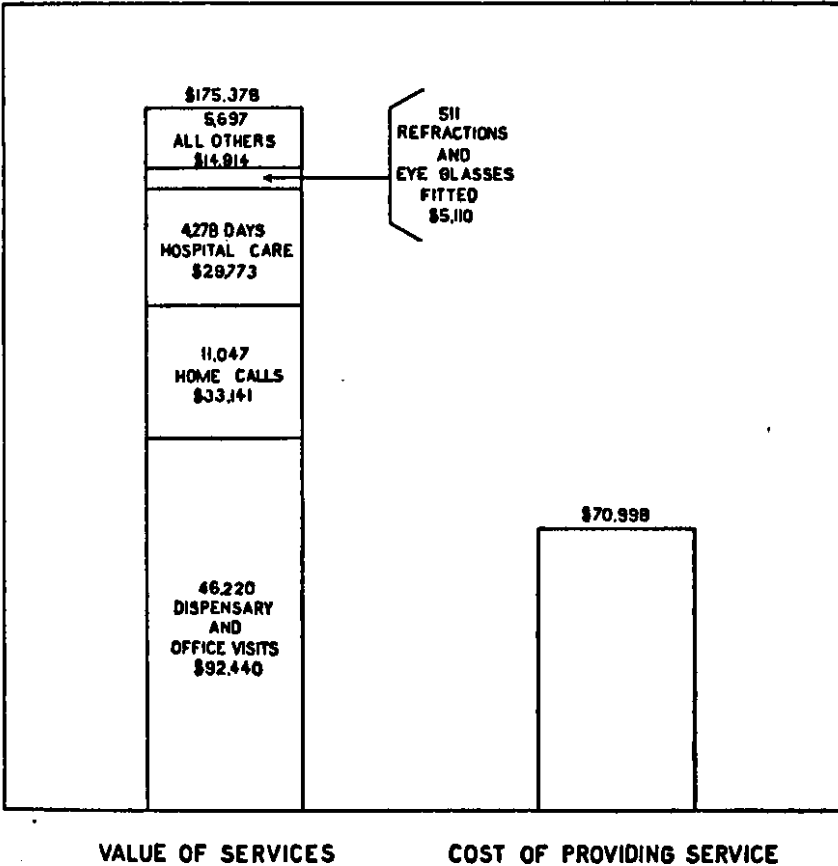


FIG. 13. THE ECONOMY OF ORGANIZATION

This diagram shows that, while the medical service furnished by the Homestake Mining Company in 1930 to 1,855 employees and their families cost approximately \$70,998, when the services were appraised at prevailing local fees (for instance, when 46,220 dispensary and office visits were figured at \$2.00 per visit), the total value of the services provided was over \$175,000. The value of hospital care includes the estimated cost of professional services to 88 medical and 348 surgical cases in the hospital.

tioners, rather than according to the services rendered.* There are now about 200 such clinics in the United States.

A variation of the private group clinic is the diagnostic clinic, sometimes conducted by physicians as a self-supporting enterprise, and at other times conducted with semi-charitable

intent. In the diagnostic clinic a group of specialists join to diagnose obscure cases. Such clinics usually accept only patients who are referred by physicians, and send the patients back to the referring physicians for treatment. Frequently a flat fee of \$50, \$75, or \$100 is charged for a complete diagnostic examination and report. Such clinics are feasible only in large metropolitan areas where there is a substantial stream of patients; and they have rarely been successful except when associated with the staff organization and therapeutic services of a hospital or general clinic.

There are two-fold advantages to group clinic practice: advantages to the patient and advantages to the practitioner. Briefly the advantages to the patient are that he may receive a better quality of care from a well-rounded group, than he would from individual physicians, practicing independently and without intimate and continuous contact with each other. This is a special advantage to the patient with an obscure illness or one difficult to treat. The clinic as a whole assumes responsibility for the quality of the patient's care, and he finds it convenient to obtain the services of all needed specialists in one place and as part of one arrangement. From the physician's point of view, clinic organization has the advantages that his time is conserved, the spread between gross and net income is diminished, a large amount of equipment is usually available, consultation with colleagues is facilitated, vacations and opportunities for postgraduate study are more readily provided, net income tends to be higher and stabilized, records are more nearly complete, and research is facilitated through the existence of a larger number of records.

A comparison of the financial aspects of group practice with individual practice presents certain problems. A special study of a number of typical private group clinics showed that among the expenses of the clinics are included many costs not usually incurred by individual practitioners, for example, laboratory and X-ray services which private practitioners usually obtain by sending patients to hospital or commercial laboratories. The average "overhead" of individual private practitioners is approximately 40 per cent of their gross income, while, for the group clinics studied, the figure was only 33 per cent. When, however, the items are considered in detail and an

endeavor made to eliminate those expenses which do not usually appear in the individual practitioner's account, the "overhead" of the clinics is reduced to about 25 per cent and, in some instances, to only 20 per cent.

The disadvantages of group practice are: there is a tendency to reduce the personal relation with patients, although many clinics guard against this, and there may be a lack of privacy for patients and a division of responsibility for their care. The physicians on salary, furthermore, do not have the same personal and professional independence that they have in private practice. Group clinics may be in direct economic competition with private practitioners, and it is sometimes alleged that this competition is "unfair." The economies of group practice in some instances are not passed on to patients, even in part. Some clinics have been dissolved because the physicians could not agree on the division of income.

It is evident that group clinics are feasible only in communities which can support several physicians.*

B. UNDER CONSUMER SPONSORSHIP

5. Medical Service Under Workmen's Compensation.—Forty-four states have workmen's compensation laws, most of which require the employer to provide money compensation and medical services to such of his employees as are injured while working for him. The employer may insure his liability through a commercial company, may self-insure, or may insure in a compulsory or optional state fund. Medical service is frequently paid for according to a fixed fee-schedule which aims to set rates comparable to those usually charged

* In the Committee's study of the organized medical service at Roanoke Rapids (Publication No. 30) it was concluded that 5,000 persons may be sufficient to support an organized medical service but that 10,000 or more are preferable. The organized medical service at Roanoke Rapids, although it serves about 10,000 persons, is not sufficiently complete to be taken as an example of the "community medical center" described in Chapter III. Of the six physicians who participate in this organization, one is chief of staff, two perform major surgery and render general medical service, one is a pediatrician and general practitioner, one is a general practitioner, and one is an eye, ear, nose, and throat specialist. Thus there is no radiologist, no pathologist, no obstetrician or gynecologist, no dermatologist, no urologist, and no psychiatrist. Some of these deficiencies could be remedied if slightly more money were available. Others are inherent in medical practice in small isolated communities and must be overcome by association with larger institutions. In the Committee's plan presented in Chapter III, organizations the size of the Roanoke Rapids service would be "affiliated branches" of community medical centers. The medical service at Ft. Benning, described in Publication No. 31, illustrates very effectively the type of organization which the Committee visualizes for community medical centers.

for such services to persons in similar economic circumstances. The payment is made by the employer, the insurance company, or the state fund, as the case may be. Service under workmen's compensation legislation, even though inadequate in some instances, has undoubtedly been of great benefit to injured workmen and has been satisfactory to physicians in some states as, for example, in Ohio where there is a state insurance fund and where the fee schedule was approved in advance by the state medical society. In some other states, there has been constant bargaining between the physicians, interested in receiving adequate payment for their services, and the insurance companies, interested in keeping down the costs of service. In a few states, the agencies which provide medical service for compensation cases also provide service for non-compensable illnesses, the employee, with or without the aid of the employer, meeting the cost of this service through wage deductions. In many states a maximum liability is specified, which is often insufficient to meet even hospital costs without professional fees.

6. Medical Service Furnished by Employers.—Industrial medical service was formerly considered synonymous with low-grade care, since industries which employed "company-doctors" were frequently more eager to get cheap service than to get good service. Often the lowest bidder was given the contract, regardless of his qualifications, and little or no equipment was provided.

There has been in recent years a substantial growth in both the quality and the amount of medical service provided by industries or by groups of employees. Most of such service is diagnostic and preventive, patients being referred to their family physicians for treatment, and is usually limited to employees and furnished without charge. In April 1930, probably at least 1,000,000 employees in the railroad, mining, and lumbering industries and a large number of their dependents were receiving medical service furnished by the employer or under industrial auspices.^a

Some industrial medical service is comprehensive and of good quality. The Endicott-Johnson Corporation, for example, provides its employees with the services of general practitioners and specialists, hospitalization, dentistry, nursing, and

laboratory and X-ray service. The service compares favorably with general practice in small cities, and in preventive medicine and obstetrics is better than that ordinarily received by working class families in such cities. In 1928 this service cost the company \$21.81 per individual to whom it was potentially available.⁴

7. Medical Service Provided by Employee Groups.—There are several hundred employees' mutual benefit associations which provide various kinds of cash and other benefits to their members.⁵ Most of these associations provide only cash benefits during sickness, but a few of them provide medical service. One of these, the Stanacola Employees' Medical and Hospital Association of Baton Rouge, Louisiana, employs a surgeon, an eye, ear, nose, and throat specialist, and five general practitioners, as well as two nurses who are laboratory technicians. Complete medical, hospital, and nursing service is furnished to the members and their dependents at a cost of \$3.00 per employee per month.⁶

8. Medical Service Provided Jointly by Employers and Employees.—Frequently industrial medical service is supported by both employers and employees. In Roanoke Rapids, North Carolina, five industrial establishments have cooperated with their employees in the development of a community medical service.⁷ Unlimited hospital care; home and hospital nursing; and home, office, and hospital attention by physicians are included. The employees pay 25 cents per week, which amounts to nearly \$33,000 per year, and the mills pay a total of \$56,000 per year. While the funds so provided are not sufficient to prevent certain inadequacies in the service, the medical and surgical care is, on the whole, of a high order.

Discussion of Industrial Medical Service.—The advantages of industrial medical service, whether furnished by the employer, the employee, or both, are in general similar, namely: (1) the form of organization makes possible a method of financing which provides more medical care than most persons in similar economic groups are able to afford under private practice; (2) both patients and physicians realize some or all of the benefits of group organization, as outlined above under "Group Clinics"; (3) although no patient pays excessively for his medical service, a total sum is made available which is sub-

stantially larger than the amount which persons in these income groups customarily pay; (4) the economic inhibition against seeking service early is removed; and (5) physicians' incomes are larger than in private practice among people of the same general economic group in communities of similar size, and physicians can obtain more leisure for study.

The disadvantages of this type of practice are: (1) since the management and direction of the service are almost entirely in the hands of laymen, it is possible for proper professional standards to be disregarded; (2) the practitioners

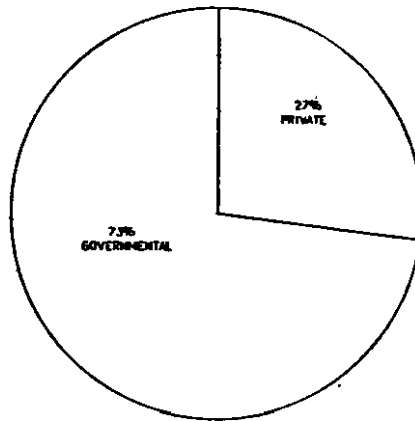


FIG. 14. HOSPITAL SERVICE PROVIDED BY GOVERNMENTAL AND BY VOLUNTARY INSTITUTIONS

This graph (based upon the patient days of hospital service in 1931) shows that approximately 75 per cent of hospital care in the United States is provided by the Federal, state, and local governments. Mental hospitals provide a large part of this service.

lose some of their personal and professional independence; (3) such a system may unfairly exploit the services of physicians; (4) the receipt of medical service often is dependent upon continued employment; and (5) in some areas, notably West Virginia, this plan appears to have been exploited jointly by the employers and the physicians or the hospitals through the provision of an inadequate service of indifferent quality. In some instances, moreover, employers have illegally used the industrial medical service as a device for unloading upon their employees the cost of workmen's compensation.*

* For example in West Virginia, according to a 1931 report by a committee of the legislature, wage deductions for medical service are sometimes used by an employer to pay the cost of

Industrial medical services are feasible, only when there are fairly large groups of employees under one management, or where a satisfactory arrangement can be made for combining smaller groups. A disadvantage frequently found, although not inherent in the plan of organization, is that dependents are not included. Finally, such a system may make the medical service of a community even more dependent upon the stability of industry than it would be under the usual private practice arrangement. The opposite, however, seems to have been the case, during the current depression, in the Roanoke Rapids service.

Industrial medical service is ultimately limited to those persons and their dependents who are employed in establishments with a considerable number of workers. Of the 211,000 manufacturing establishments in the United States in 1929, only 29,000 employed over 50 wage-earners as a yearly average, although their total employees numbered 7,000,000 of the 9,000,000 in all manufacturing establishments. If employees of other types of organizations of suitable size be added, the 7,000,000 might be increased to 10,000,000 or 12,000,000 employees, with 20,000,000 to 30,000,000 dependents, giving a total of 30,000,000 to 40,000,000 persons who might conceivably be served by industrial medical services.

C. UNDER COMMUNITY SPONSORSHIP WITH PROFESSIONAL PARTICIPATION

9. Middle-Rate Hospital Services.—A number of voluntary hospitals in this country are now developing special plans for the so-called "patient of moderate means."⁸ The most significant feature of these, as illustrated, for example, by the Baker Memorial unit of the Massachusetts General Hospital, is an agreement between the medical staff and the hospital on a fixed maximum schedule of charges for professional as well as for hospital services, and the adjustment and collection of these charges by the hospital administration, acting on its

hospitalisation for his employees suffering from industrial accidents as well as, and in some cases to the exclusion of, employees suffering from non-compensable cases.

⁸ See Pierce Williams, "The Purchase of Medical Care Through Fixed Periodic Payment," (National Bureau of Economic Research, New York, 1932) p. 189-190.

own behalf, and as the agent of its medical staff. An effort to reduce the cost of special nursing is usually an additional feature.

Other hospitals now have flat-rate charges for maternity cases, for tonsil and adenoid cases, and for laboratory service. Some provide for payment of hospital bills in weekly or monthly installments. Several diagnostic clinics, some of which are in hospitals, have flat-rate charges for a complete diagnostic examination. Hospital work under most of these plans is largely if not wholly self-supporting. When deficits occur, they are usually met by public contributions.

Such arrangements enable the patient, *when he becomes sick*, to estimate how much he must spend, and frequently enable him to have the kind of service which he wishes without too great expense. The physicians are also benefited since they can collect something from patients who might otherwise be forced to go without care, or who might use ward services and pay the physicians nothing.

On the other hand, such measures are inadequate. They are largely limited to persons in the middle economic groups. They do not make it easier for people to budget their medical expenditures in advance of illness; they do not encourage either patients or physicians to use preventive measures; and they enable only a small proportion of the lower income groups to pay for satisfactory medical care. Since they provide only for a special economic group, they are feasible only where that group is large, *i. e.*, in cities and large towns.

10. Pay Clinics.—Out-patient departments of hospitals and clinics independent of hospitals were originally only for the very poor. Increasingly they have come to serve persons who are not indigent, but who cannot meet the usual expense of private medical care. A large number of clinics, particularly in the Eastern cities, have begun, since the war, to charge fees for service, usually of nominal amounts, but, in an increasing number of clinics, of amounts nearly or quite sufficient to cover the actual expenses. In many of these clinics, the physicians are nevertheless expected to give their services without charge.

Pay clinics, however, are those in which the physicians are compensated for their services on a salary or fee basis, and

the patient pays the full cost of the service, except, as in hospitals, the capital charges. Some pay clinics, like the Cornell Clinic in New York City, provide general services; others are limited to special fields.

Dental clinics of various kinds are developing in all parts of the country and perhaps an appreciable number of them are conducted on the "pay clinic" principle.⁹ Hospitals direct more dental clinics than any other single agency.

Pay clinics furnish good care to persons of small means at a much lower cost, due to the economies of organization and the limitations on the returns to practitioners, than the cost of equivalent service in private practice; but they compete with some local medical practitioners and, unless well organized may provide hurried and impersonal service.

11. Private Office Practice in Hospitals.—In the past, hospitals have been typically used for the care of both paying and non-paying bed patients, and non-paying ambulatory patients. Paying patients who are ambulatory or "office" cases usually have not been received in hospital buildings. Recently, however, the medical staffs of many hospitals have arranged to utilize the hospitals for their private office practice by referring cases for X-ray or laboratory service, by using rooms for consultations or conference with other hospital staff members on private cases, or by actual rental of office space in a hospital building. Data accumulated by the Council on Medical Education and Hospitals indicate that in 1931 nearly 1,000 hospitals were used to some degree by 4,500 physicians who maintained offices or office hours for private ambulatory patients in the institutions.

These procedures have increased the individual practitioner's opportunities to serve cases requiring specialists or diagnostic equipment; they may conserve the physician's time in the treatment of his private cases, and the patient's time also in some instances. From the hospital's point of view, this use of the institution's facilities has had the advantage of increasing the amount of service rendered by the equipment and apparatus, and thus lowering the unit-costs of certain hospital functions and increasing revenue.

The tendency to concentrate private office practice in hospitals faces certain possible difficulties. First, it may give rise

to competition with previously established commercial agencies providing X-ray or laboratory service. Second, some institutions may extend privileges on an uneven or undesirable basis among members of the medical staff or the local profession. Third, the hospital may be embarrassed by demands that office facilities be provided to all members of the staff.

12. Public Health Nursing.—One of the most significant tendencies of the past quarter-century has been the development of public health nursing, under both official and non-official auspices. The visiting nurse, originally employed to care for the sick in the home, has broadened her scope to include health teaching as a major objective; so that public health nursing is now defined as an organized community service rendered by graduate nurses to the individual, the family and the community. This service includes the interpretation of medical, sanitary, and social procedures for the correction of defects, prevention of disease, and promotion of health as well as domiciliary nursing care.

There are two major groups of public health nurses now in service, those employed by official agencies, who commonly devote their time to purely educational work, and those employed by voluntary agencies who also render bedside care for the sick. There is a tendency, however, to consolidate all types of public health nursing in a given community so that a single nurse may render complete generalized service to a given population unit (preferably of not more than 2,000 persons).

Public health nursing provides, mainly to low-income families: health supervision service, maternity service, and bedside care and other services to the sick in their homes. School nursing service in the school and in the home and industrial nursing service both in the plant and in the home include some or all of the above services. Non-governmental nursing nearly always have a medical advisory board to assist in defining the work which the nurses may do. The nurses are expected to cooperate with the industrial or family physician. Financial support comes from tax funds, from public contributions, from payments by life-insurance companies for services to their policyholders, and from fees which are charged only to patients who are able to pay. Public health nursing is available theoretically to all groups of the population, regardless of economic status,

both on a visit and part-time basis, although as yet the middle and upper economic groups use it infrequently.¹⁰

The outstanding advantages of public health nursing are that it makes a limited amount of nursing service available to many families who cannot afford to employ full-time nurses or who need only occasional nursing, and it offers an excellent opportunity for health instruction of families by example as well as by precept. Every public health nurse is expected to teach her families as much as she can about nutrition, personal hygiene, and social and mental adjustments.

The significance of this movement is that well-organized community agencies, with high professional standards, supply all needs for preventive and curative nursing care in a population group on terms which make the service potentially available for all economic levels.

13. Organized Service by Trained Nurse-Midwives.—About 15 per cent of the childbirths in this county are attended by midwives. In 1925, approximately 300,000 births were cared for by such practitioners, most of whom are untrained, dirty, and superstitious. In contrast to them are a few trained nurse-midwives who handle normal obstetrical cases very effectively. These women are far superior in general education and obstetrical training to the average untrained midwife of the Southern states. The best known example of the use of trained nurse-midwives in this country is the Frontier Nursing Service of Kentucky, whose nurses delivered 818 patients during the six years ending May 1, 1931, with only one maternal death.¹¹ This organization offers also the customary public health nursing services, a modicum of hospitalization, and from time to time special services of physicians and dentists. The total cost of this service, even though it is carried on in a very remote mountainous region, is only \$10.92 per year per person actually served. Because of the poverty of the patients, however, over 95 per cent of even this modest sum must be collected outside the community.

The advantage of this plan is that it brings skilled nursing and midwifery service, on an economical and efficient basis, to families which could not possibly pay the not unreasonable fees of the nearest physician. The same advantage would be realized, although perhaps to a less degree, in the use of

trained nurse-midwives for any low-income group or any group in sparsely settled areas.

The disadvantages of using nurse-midwives are that they are not competent to handle unusual or difficult deliveries, and that, if used in areas where there are physicians, they would care for some patients who otherwise would have the services of a physician.

14. Trained Nursing Attendants.—In Boston, Detroit, and Brattleboro, Vermont, women have been trained as “nursing attendants,” to do simple home nursing under the direction of trained public health nurses and, in addition, to perform necessary house work. Charges for such service are somewhat lower than those customarily made by trained nurses.*

Such a service is particularly useful when the homemaker is too ill to carry on her ordinary duties, but not ill enough to require the continuous care of a graduate nurse. It is desirable only when the work of the attendants can be carefully supervised. Eventually it may be provided by a variety of organizations which are in a position to exercise the necessary supervision and control.

15. Expansion of Governmental Health Services.†—Local and state governments have long provided treatment for infectious diseases, especially for tuberculosis, for mental diseases and, more recently, for venereal diseases. In some instances they are beginning to offer treatment of cancer and orthopedic cases. In addition, it has been proposed that the local or state government take up the whole problem of the care of chronic patients.

All these diseases or conditions are very costly to the patient, either because of the nature of the treatment or the long duration of the illness. It is advantageous, therefore, that he be given good care at an early stage in order to avoid, if possible, the disastrous physical and financial effects of a long-continued illness. In many instances he must have some sort of assistance if he is to obtain proper care. From the stand-

* Publication No. 17. At the present time unemployment is so extensive among graduate nurses that many of them are working or would willingly work for rates below those customarily received by trained attendants.

† *Dissenting Statement By Committee Member.*—I believe that governmental care of patients is to be condemned except in the case of illnesses which may involve danger to public health and safety, e. g., tuberculosis, venereal diseases, mental diseases.—J. Shelton Horaley.

point of the private practitioner, it may be desirable to have an organized governmental medical service provide care to these chronic cases, since then the practitioner need not continue treating them long after they have ceased paying him.

The chief disadvantage of such an expansion is the one common to all governmental activities, namely the danger that such services may be subjected to purely political interference, or stifled by a poorly organized civil service. In addition there is the disadvantage—not to be lightly dismissed—that the medical care of families, and perhaps of individuals, may thus be divided among several persons or agencies.

In addition to the development of services for special types of disease, there have been significant growths in two of the accepted public health services, namely, public health nursing and school health service. Public health nursing has been discussed on p. 86-87 above.

Since the first law which provided for medical inspection of school children was passed by Connecticut in 1899, there has been a rapid and substantial growth in school health service in both elementary and high schools. Most of the work for school children is preventive and diagnostic: medical inspection by school physicians, dentists, nurses, and teachers; examination of children returning to school after illness; examination of children about to enter school; and instruction in diet and hygiene. In some school systems, however, certain therapeutic services are also provided, such as the removal of diseased tonsils or adenoids, the filling of dental cavities, the provision of eye-glasses, and the treatment of mental maladjustments.

16. Government Provision of Hospitalization.—Cities and counties have for a long time provided hospitals for the care of the indigent. In recent years some local governments have experimented with the plan of providing hospitalization at moderate rates to *all* classes of the population. Both Cincinnati and Buffalo have large general hospitals open, under certain restrictions, to all residents. Many cities and counties pay non-governmental hospitals on a per capita per diem basis for the hospital care of the poor. Often such payments do not equal the cost of service.

The advantage of governmental aid in the provision of hospital service is that it enables hospitals to render service at lower charges and thereby assists patients in meeting the costs of hospitalized illnesses, which include about 50 per cent of the total costs of all medical service. In some areas, tax funds must be used if hospital service of any kind is to be provided. If state, city, or county aid is given to non-governmental hospitals, the governmental agency can set minimum standards for hospital administration and practice.

On the other hand, since hospital service is only one aspect of medical care, this plan does not solve the problem of providing satisfactory medical service to all who need it. Furthermore many persons hesitate to approve governmental provision or support of hospitalization, because they believe that governmental effort, more frequently than comparable private effort is associated with waste, extravagance, and incompetence. This belief, however, at present rests far more on impressions than it does on adequate factual proof.

17. Tax-Supported Physicians in Rural Areas.—In 30 or more rural "municipalities" * of Saskatchewan ¹² one or more physicians have been employed to provide medical service. About two-thirds of the physicians are on a whole-time basis. These physicians are usually also appointed local health officers. The cost of their services, paid through tax funds, is about \$7.50 to \$10 per family per year.

This system, which was started about 1921, provides physicians with incomes and favorable working conditions and assures their services to many communities which otherwise would not have resident physicians. The costs are so distributed that no individual patients or families are heavily burdened. Early consultation is encouraged, yet there is little tendency among patients to take up the doctor's time for trifling ailments. Preventive measures are utilized freely. Some of the doctors say that their relations with patients are more cordial than when a fee was charged for each service, and, they are saved much financial worry and clerical detail. No community in Saskatchewan which has adopted the "municipal doctor" plan has abandoned it.

* A "municipality" corresponds in most respects to a county in the United States.

The principal disadvantage of the plan is that it is limited to general practitioner's services. It usually does not include hospitalization, nursing, dentistry, and the services of specialists, but, under the usual conditions in other rural areas, these services are available, if at all, only at high cost. Some municipalities have added one or another of these services. The possible disadvantages of salaried practice have been mentioned earlier.* None of these disadvantages has seriously hampered the work in Saskatchewan.

18. State Aid for Local Medical Service.—Several states have found that adequate local public health service probably will not be provided without state financial assistance. One state, New York, has authorized the state department of health to reimburse any county to the extent of one-half its expenditures for the construction, establishment, or maintenance "of a county, community or other public hospital, clinic, or dispensary or similar institution," or "any public enterprise or activity for the improvement of the public health," provided the enterprise is approved by the State Department of Health. In spite of the broad terms of the act, most of the money so far appropriated under it has been for the support of public health activities, and relatively little for direct medical and hospital services.¹⁸

The advantages of state-aid on a "matched-funds" basis are: (1) it assists rural counties and other counties with relatively low tax incomes to support more nearly adequate medical service than they could otherwise afford; (2) it gives the state a more effective leadership in the development of needed services in rural areas; and (3) it does not deprive the local community of its initiative, responsibility, and control over its own medical services.

Obviously, state aid is not a desirable policy if the officials in charge of its administration are uninformed of or unsympathetic with local needs, or if they attempt to control local activities for political purposes.

19. Insurance for Hospitalized Illnesses.—Several plans have been tried for assisting patients in meeting the costs of the

* See p. 79, 82, of this chapter.

more expensive illnesses. Some of these, such as the hospital insurance offered by the Baylor University Hospital of Dallas, Texas, and by the Community Hospital of Grinnell, Iowa, cover only the cost of hospitalization.¹⁴ Plans of a similar nature are now being adopted or considered in a number of hospitals in the East and Middle West. In these plans, the hospital deals with organized groups of persons who pay a fixed amount per year into a common fund out of which their hospital bills are met. In several instances, a group of hospitals in the same community are endeavoring to work out a joint plan. In Brattleboro, Vermont,¹⁵ and New Bedford, Massachusetts, a somewhat similar type of insurance, covering also part of the cost of professional services, has been offered to individuals instead of to groups. In Great Britain, voluntary insurance for hospital care has recently extended with great rapidity and now covers about six million persons.

The principal advantage of such insurance is that, since it provides financial aid only to those patients who have high-cost illnesses, *i. e.*, illnesses associated with hospital, surgical, or nursing services, its cost is much less than insurance for all forms of medical expenditure. Physicians, nurses, and hospitals gain from such plans since some bills are paid which, in the absence of an insurance plan, would not be paid. Furthermore, practically no financial risk need be involved in the initiation of such plans, and a relatively simple type of organization suffices to administer them.

On the other hand, this type of insurance must provide for physicians' services, hospitalization, dentistry, and nursing if it is to include all the major items which can and do cause "high-cost" illnesses.¹⁶ Since it is usually much more limited in scope, it does not fully solve even the problem of high-cost illnesses. Furthermore, this insurance does not encourage families to provide medical service promptly in case of illness, or fully to utilize preventive services; nor does it take advantage of the economies possible in group work.

20. University Medical Services.—Since student health departments were started as early as 1860, experience with this type of service has been extensive. On January 1, 1931, there were 153 colleges or universities with organized divisional

student health services. Many of these provided a complete medical service at costs of \$9.00 to \$30.00 per capita per school year. At the University of California, physicians' services, dentistry, hospitalization, laboratory service, physical-therapy, x-ray service, and drugs are furnished to 9,800 students in residence at a cost, including capital charges, of \$17.86 per eligible student for the school year.¹⁷ This service has most of the advantages of industrial medical service, and the further advantage that the university, with its tradition of high professional standards, instead of the industry or the employee benefit association, occupies the position of leadership. There are, at present, approximately 1,086,000 college students and 85,000 college and university teachers in the United States. If such service were extended to all students, all faculties and their families, and all other university employees and their dependents, it would probably reach a maximum of about 1,300,000 persons.

21. Health, Hospital, and Nursing Councils.—There are in the United States at least a dozen health councils, the oldest of which was formed in 1917. The Cleveland Health Council, which may be considered representative, acts as a cooperative agency to coordinate public health work. Through group planning and expert study, it attempts to prevent the placing of undue emphasis on certain health problems at the cost of others, to discover gaps in the community's health program, and to build up services and initiate new programs.¹⁸ Similar activities for hospitals are carried on by a number of hospital councils. In five cities, nursing councils study the nursing needs of the community, promote measures to meet these needs, and help prepare nurses for service.¹⁹

After more than ten years' trial, it is now clear that when health councils are provided with competent personnel, necessary funds, and able guidance, they can exert needed leadership in public health activities, can coordinate activities that are overlapping and disjointed, and can successfully sponsor the development of new health activities, even though, as is usually the case, they have neither legal nor financial control over the various health agencies.

The principal limitation of health councils as now constituted

lies in the fact that they usually consider only public health problems and do not embrace the equally important fields of medical service to individuals. Adequate and able representation of the medical, dental, and nursing professions in such councils is essential.

D. UNDER JOINT SPONSORSHIP OF PROFESSIONAL AND CONSUMER GROUPS

22. Periodic Payment Plans of Group Clinics.—At least a dozen private group clinics now provide medical service to groups of persons for periodic payments. Usually these plans are worked out at the suggestion of and in cooperation with consumer groups. The Ross-Loos clinic in Los Angeles, for example, at the request of a group of employees, began about three years ago to offer medical service complete except for dentistry and nursing, to several such groups. The number of subscribers has grown steadily, and includes at present about 9,000 persons who pay \$2.00 per person per month. In addition, laboratory service and the services of physicians are offered to family dependents without charge, although dependents pay cost prices for hospitalization, drugs, and a few other items.²⁰ The various employee groups meet with the clinic directors periodically to discuss questions relating to the medical service.

This method of payment has proved popular with patients, and it is being steadily extended in various parts of the country. It has all the advantages of industrial medical service, and in addition the advantage that the control of medical service is in the hands of the practitioners who direct the clinic, while the formation of policies is shared by representatives of the patients.

The most important disadvantage of this service, as at present operated, is that there is an increased opportunity for clinics to engage in competition as to price, which is disastrous to professional standards and therefore to the welfare of patients. In fact, such competition has already appeared in California, Washington, and some other states and, to date, no method of controlling this abuse has been effective. There are,

in addition, the disadvantages of group clinic practice, which were listed above.*

E. UNDER COMMERCIAL SPONSORSHIP

23. Installment Payments Through Loan Companies.—Within the last decade attempts have been made to systematize the paying of medical bills through installment payments. A number of proprietary organizations have been formed to purchase the accounts of practitioners and collect what they can, or to advance money either to the patient or the practitioner and collect from patients. These associations have not yet reached large proportions. But "loan sharks," remedial loan associations, and personal finance departments of established banks also are extensively used to provide funds to meet medical expenses. About 28 per cent of all such loans are for this purpose. The annual interest rates on these loans vary from 12 to 43 per cent or more.²¹

The installment plan, however, does not provide funds which otherwise would not be available. In fact the interest rates increase the total burden. The burden of payment is spread over a period of time, but it is not so distributed that the public helps to lighten it when it threatens to destroy the solvency of the patient.

24. "Health Insurance" Provided by Insurance Companies.—Many commercial companies offer "accident and health" policies which provide limited cash benefits to meet the costs of medical care. None of them provides medical service, except occasionally nursing. These policies are usually

* *Dissenting Statement by Committee Member.*—This paragraph overstates the disadvantages. In a number of towns in the Middle West where this form of medical service is in operation, no such difficulties have appeared. The undoubted evils of competition as to price exist among physicians in private practice and are emphasized where, as in many cities, there is a local over-supply of physicians. Complaints by physicians who feel themselves injured by a competitive process do not necessarily imply that the process is injurious either to the profession as a whole or to the public. Group practice may render certain evils of competition more apparent, but for this very reason they may be more susceptible to control. The above paragraph refers to the situation on the Pacific Coast as if it were full of hopeless evil, whereas it has undoubtedly extended medical service to many persons and stabilized, if not increased, the incomes of a considerable number of physicians. The vigorous efforts now being made by professional bodies in those states to deal with its evils may be expected to bring these in hand within the near future, not, however, by suppressing plans of group payment and group practice, but by adjusting them under proper professional and public control.—Michael M. Davis and Louis I. Dublin.

limited to certain classes of people, and, even when sold on a group basis, are too expensive to be of wide-spread value.

25. Medical Benefit Corporations Operating for Profit.— Particularly in California, a large number of medical benefit corporations, organized by laymen for profit, sell health insurance policies to individuals and provide service through contracts with individual practitioners and hospitals. In some cases, the corporations write group contracts with employees and arrange for the employer to collect the premiums.²² One such company planned to use 25 per cent of its income to pay physicians and the remaining 75 per cent for selling costs and profits.

This plan has some disadvantages which are unique. In the first place, it is under neither professional nor community control, and the insurance departments of the State of California and other states have refused to exercise jurisdiction over such corporations. As a consequence, many companies have started with inadequate capital and reserves, only to fail. In the second place, the management is entirely lay and relatively unconcerned with professional standards. Much of the medical service has been obtained from the lowest bidder, although sometimes it is paid for at the workmen's compensation rates. Finally, this plan, instead of obtaining the economies and professional advantages of group organization and group practice, actually adds to the cost through expensive selling procedures and payment of profits to owners.

F. EUROPEAN DEVELOPMENTS IN THE PROVISION OF MEDICAL CARE

In Europe, as in the United States, the provision of medical service is mainly in the hands of individual practitioners although hospitals are well developed and, in some localities, clinics and other forms of group practice provide medical care in conjunction with group payment by insurance or taxation.

During the past fifty years, most European countries have made payment for medical care the subject of public action and a large part of the population now pays for medical service through regular periodic payments to a mutual benefit society or health insurance "fund." These funds are non-profit

organizations formed of the employees of a given establishment, of all insured persons in a given locality, or of the members of a fraternal or cooperative society who may be scattered throughout a whole country. Such funds are under some government supervision, but usually are not administered by the government. As a rule the payments made by the wage-earner are supplemented by approximately similar amounts paid by his employer; in some countries a payment is also made from tax funds. These sums together make up a total from which are paid (a) certain expenses of medical service, and (b) a cash benefit in partial re-payment of the loss of wages during illness.

Hospital care in Europe, except in Holland and Great Britain, is predominantly supported by taxation. In the latter country, a great extension in hospitals under government auspices has taken place in recent years. In some countries a few health insurance funds maintain their own hospitals or sanatoria but, in general, hospital care is not part of insurance schemes. Payments from insurance funds may, however, meet part, but usually only a small part, of the cost of care of insured persons in government hospitals. In England, voluntary insurance against hospital care is increasing. Almost everywhere in Europe, the typical general hospital does not receive private paying patients in the American sense. The medical staff of a European hospital is usually composed of a small number of physicians on salary, who do not carry on any private practice. Thus only a small proportion of the medical profession have direct contact with hospital service.

In most countries of Europe, every employed person earning less than a specified income is legally compelled to insure himself against illness, and the insurance fund to which he belongs must in return provide him with certain medical services. Additional services may be furnished if the workers and employers choose to assess themselves larger amounts. In all these countries, voluntary insurance on a cooperative, non-profit basis, preceded the adoption of any legal requirement to insure. In many European countries, insurance is also provided against industrial accidents, invalidity, old age, and other hazards.

The scope of the medical service provided by insurance plans

varies widely. In Italy, only the treatment of tuberculosis is provided; only the services of general practitioners are offered in Great Britain; in most of Germany and Austria a nearly complete medical service is given. Complete medical care in all forms is not provided in any insurance scheme.

The British system requires all employed persons earning less than £250 annually to insure, and furnishes cash benefits together with the services of general medical practitioners and such medicines as they prescribe. Hospitalization; dentistry, the services of specialists, and the medical care of dependents are not included, although dental care has not infrequently been added by voluntary local action. The British Medical Association opposed the insurance scheme at its inception in 1912 but has now officially recognized its benefits and advocated an extension of the scope of service and the inclusion of dependents.

Germany passed its first compulsory health insurance law in 1883. It applied only to certain industries in which voluntary insurance had already developed. Succeeding legislation has greatly extended the system both in the number of persons served and in the range of benefits provided, so that now almost two-thirds of the entire population are covered. Since the War, voluntary insurance has been extending rapidly among persons who are above the economic limit of the compulsory insurance system.

France introduced compulsory health insurance only in 1930, providing medical and cash benefit for persons whose income does not exceed 18,000 francs. Russia under the Soviet régime is the only country in Europe which has undertaken state medicine, with medical services and facilities provided and administered by the government. Denmark, which with Sweden depends on voluntary insurance, has brought the majority of the population under the system. In Denmark the individual is not legally required to insure against illness, but he has many indirect incentives to join and faces certain legal disadvantages if he does not.

The system of furnishing medical service and of remunerating physicians and other practitioners varies greatly. In Great Britain, every physician may undertake insurance practice if he wishes and he is remunerated at a fixed amount per patient

per year. Free choice of physicians among those wishing to accept insurance practice is assured. In Germany and elsewhere on the continent, physicians are usually paid according to an agreed scale of fees worked out between the insurance funds and the physicians. Salaried physicians are employed in some localities and consultation clinics and other special clinics, which employ full-time or part-time physicians, are increasing. Under the recently enacted French law, fees for medical and dental attendance are paid directly to the physicians or dentists by insured persons, according to a fixed scale, but any practitioner may charge beyond this scale if the patient agrees. The patient is reimbursed by the insurance fund up to the amount of the official fee schedule only.

Thus, in general, European countries have focused their attention upon the problem of payment rather than upon methods of providing medical care. Relatively little attention has been given to the relation of insurance practice to preventive work, although there are evidences in England and in some localities upon the continent of increasingly close relations. Care of the indigent is almost everywhere a direct responsibility of government and is often furnished by salaried physicians. Methods of group payment for medical service have been utilized through two generations and in many countries with widely varying social, economic, and political conditions. This experience provides a massive and growing body of detailed information regarding policies and administration. The working relations between the medical profession and the insurance system have reached a high point of cooperation in Great Britain and Scandinavia. In Germany there are wide differences between localities, and some severe local conflicts have occurred.

Only the barest summary is possible within the present limits of space, but some suggestive conclusions may be quoted from two recent and comprehensive studies of medical service in Europe. A. M. Simons and Nathan Sinai conducted in 1931 a study of the professional and economic problems of health insurance for the American Dental Association.²⁸ Their principal findings were:

1. There is practically no important opposition to the principle of health insurance in any country where it now exists. There is criticism in plenty and constant effort to change details, but no agitation for repeal.

2. The national associations of physicians and dentists have, over and over, formally approved the provision of health care to the lower-income classes through insurance.

3. There is practically unanimous agreement that the insured receive better medical care than they did before they were insured.

4. There is wide variation in professional incomes under insurance; but they will average at least as high and probably somewhat higher than they were in private working-class practice before insurance.

5. Every attempt to apply the principles of voluntary insurance on a large scale has proved to be only a longer or shorter bridge to a compulsory system. Every so-called "voluntary" system is successful in just about the proportion that it contains compulsory features.

6. In every insurance system there has been a fairly steady increase in the number of persons sick and in the number of days of sickness per capita annually. The tendency seems sufficiently well established to justify the conclusion that universal free medical service does not reduce the amount of recorded sickness.

7. A comparative study of many insurance systems seems to justify the conclusion that the evils of insurance decrease in proportion to the degree that responsibilities, with accompanying powers and duties, are intrusted to the medical professions.

The conclusions of Sir Arthur Newsholme in *Medicine and the State*, terminating his series of international studies of medical service in Europe, may be summarized as follows: ²⁴

1. The advance of medicine has made it impossible for doctors individually to meet a large share of the medical needs of the community. Close cooperation between general practitioners and specialists is required. Without it, the efficiency of medical service is reduced by inadequacy and discontinuity.

2. The problem of medical care has ceased to be one which can be solved by direct family payments and it has become one of determining the best method for securing satisfactory medical care when needed by provident measures (insurance) supplemented perhaps by communal aid (taxes).

3. If the family is to continue to be the unit of medical practice then a team of medical practitioners and not an isolated practitioner should be the unit on the medical side.

4. In every national health insurance plan in Europe, financial as well as medical aid is given during illness and in most countries the insurance is obligatory. These two facts of compulsion and the dependence of monetary benefits on medical certification, especially the latter, have given rise to trouble. The separation of medical service and cash benefit has been suggested. But medical certification would continue to be needed. The problem of certification is largely one of morale. Education among the insured will help them to realize the mutual character of insurance. It will probably also be necessary to give the insured a direct personal interest in keeping cash benefits to a minimum.

5. In recent years, public health authorities have provided, not only much hospital treatment, but also certain specialized services. The most important are pathological and other facilities for diagnosis and provisions for medical care of motherhood and childhood.

6. In European experience, the care of parturient women by trained midwives has been associated with a high standard of safety in childbirth.

These twenty-five types of development in the United States and the many developments abroad show a ferment at work in medical practice which contains great possibilities for good and evil. The Committee is aware of the fact that some of the plans are mere attempts to capitalize for private gain the people's need for better medical service. It is equally aware of the dangers inherent in other plans. Each should be viewed as an experiment and subjected to the careful evaluation that is given in a scientific laboratory. Some of them appear to the Committee to be very promising.

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1. Data from unpublished correspondence with secretaries of county societies.
2. Publication No. 8.
3. From data in Pierce Williams, *The Purchase of Medical Care Through Fixed Periodic Payment* (National Bureau of Economic Research, New York, 1932).
4. Publication No. 5.
5. Dean K. Brundage, "A Survey of the Work of Employees' Mutual Benefit Associations," Reprint No. 1506 from the *Public Health Reports* (U. S. Public Health Service, Washington, 1932).
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9. Miriam Simons Leuck, *A Study of Dental Clinics in the United States* (University of Chicago Press, Chicago, 1932).
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17. Publication No. 19.
18. Miscellaneous Contributions No. 12.

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20. Miscellaneous Contributions No. 13.
21. Miscellaneous Contributions No. 5.
22. Pierce Williams, *op. cit.*, Chapter III and R. G. Leland, "Contract Practice," *Journal of the American Medical Association*, March 5, 1932, p. 805-815.
23. A. M. Simons and Nathan Sinai, *The Way of Health Insurance* (University of Chicago Press, Chicago, 1932).
24. Sir Arthur Newsholme, *Medicine and the State* (Williams and Wilkins Company, Baltimore, 1932) p. 288-95.

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CHAPTER V

THE RECOMMENDATIONS OF THE COMMITTEE

The plan for satisfactory medical service outlined in Chapter III can best be attained, the Committee believes,* by a process of evolution. The growth should come mainly from existing institutions and organizations. In fulfillment of its accepted responsibilities, the Committee states in this Chapter its concrete recommendations for the attainment of satisfactory medical service. Before it presents specific steps, however, the Committee states its philosophy and intent in preparing its recommendations.

THE PHILOSOPHY AND INTENT OF THE RECOMMENDATIONS

The Committee approaches its task of formulating recommendations with substantial agreement on the following:

1. The problem of providing satisfactory medical service to the people of the United States at costs within their means is one of paramount importance. Its solution will be of immense economic and social significance.

2. Some of the social problems facing civilization today present almost insuperable barriers, barriers arising from the very biological nature of man. This problem is not among them. It can be solved.

3. The problem is complicated and differs from one region to another. No panacea is available; no solution is applicable today to all areas of the country. Americans are prone to think of the United States as comparable to such nations in western Europe as France, England, and Germany. Actually this nation more nearly resembles the continent of Europe as a whole; it has prosperous rural regions like Denmark, closely knit industrial districts like Belgium, and mountainous and desert regions which present social and economic questions almost as difficult as those found in a Balkan province. Forty-five per cent of the population of the continental United States in 1930 lived in cities or metropolitan areas, containing at

* This chapter presents the report of the majority of the Committee. All references in it to "the Committee" mean the majority of the Committee. The minority reports are presented on page 161, *et seq.*

least 100,000 persons. The total population was distributed as follows: *

	Number	Per Cent
Cities of 100,000 or more and their metropolitan areas...	54,754,000	45
Cities of 15,000 to 100,000 (not included above).....	8,419,000	7
Towns of 2,500 to 15,000 (not included above).....	12,747,000	10
Rural areas and towns of less than 2,500 (not included above)	46,855,000	38
	122,775,000	100

Among these population groups there are wide variations in cultural attainment and in standards of living. This means that there are wide variations in the kind of medical service which is demanded. Although in every case the service should be scientific, some groups of the population expect refinements not as yet demanded or appreciated by others. Thus there are also wide variations in the costs of the service. No single plan, therefore, is adaptable to all of America's regional variations in economic resources and activities, cultural and educational developments, density of population, and social attitudes.

4. Goals are more important than institutions, since service is the only purpose of organization. None of the recommendations proposed subsequently is of value, in the Committee's estimation, except insofar as it contributes to providing the people with satisfactory medical service or assists them in meeting the costs for such service. Institutions demand careful study, however since faulty institutions may retard or prevent the attainment of goals.

5. The recommendations vary in importance, in scope, and in immediate applicability. Some are applicable only to urban areas; others only partially solve the problem. Some of the recommendations could be applied immediately, whereas others must await further evolution of medical practice and the development of an informed public opinion. The Committee believes that its obligations require it to think ahead for twenty or thirty years, as well as for the next five or ten years and to present distant as well as immediate goals.

6. The Committee's obligation is not merely to recommend those steps which it deems immediately expedient but also

* Fifteenth Census of the United States, 1930, Volume I, *Population—Number and Distribution of Inhabitants*, p. 15, and *Metropolitan Districts, Population and Area*. The definition of "metropolitan areas" adopted by the Bureau of the Census was used in these tabulations. It is, perhaps, somewhat too restricted for present purposes.

those which, in the judgment of the Committee, communities must eventually take if they are to solve the problem.

7. An evolutionary process is now going on in medical practice and in the relationships between medical science and medical practice. This process is greatly influenced by rapidly changing economic and social conditions. Serviceable recommendations must be in line with existing trends. The most fundamental of the Committee's recommendations grow out of American experience and together constitute a plan which appears superior in certain respects to existing plans in other countries.

8. The present economic depression is forcing economy in nearly all expenditures, no matter how desirable their object. The Committee does not propose the immediate adoption of programs which involve sudden large increases in expenditures from public or private funds. On the other hand, the existence of a depression is no excuse for craven thinking regarding the future. Depressions are not new. In spite of them, the per capita income of the nation, measured in terms of 1913 dollars, increased by 30 per cent from 1909 to 1928. There are valid reasons for believing that the United States, emerging from the present experience, will continue her economic advance, with consequent increases in the funds available for the purchase of commodities and services. The greatest rewards will come to the people, moreover, from the expenditure of the larger part of their increased income on services rather than on commodities, and among these services medical care is one of the more important.

9. The interests of the 1,100,000 persons in the United States who furnish medical service and the 123,000,000 who receive it are closely interwoven. The professional standards of physicians, dentists, nurses, pharmacists, hospitals, and other practitioners and agencies which furnish medical care must be carefully guarded in behalf of the people served, as well as in behalf of those who provide service.

10. The Committee is not dogmatic in its recommendations. They are based on the study of certain groups of facts which have revealed needs or which give ground for believing that methods tested in some undertakings will be of benefit if wisely applied on a larger scale. The aim should be to adopt

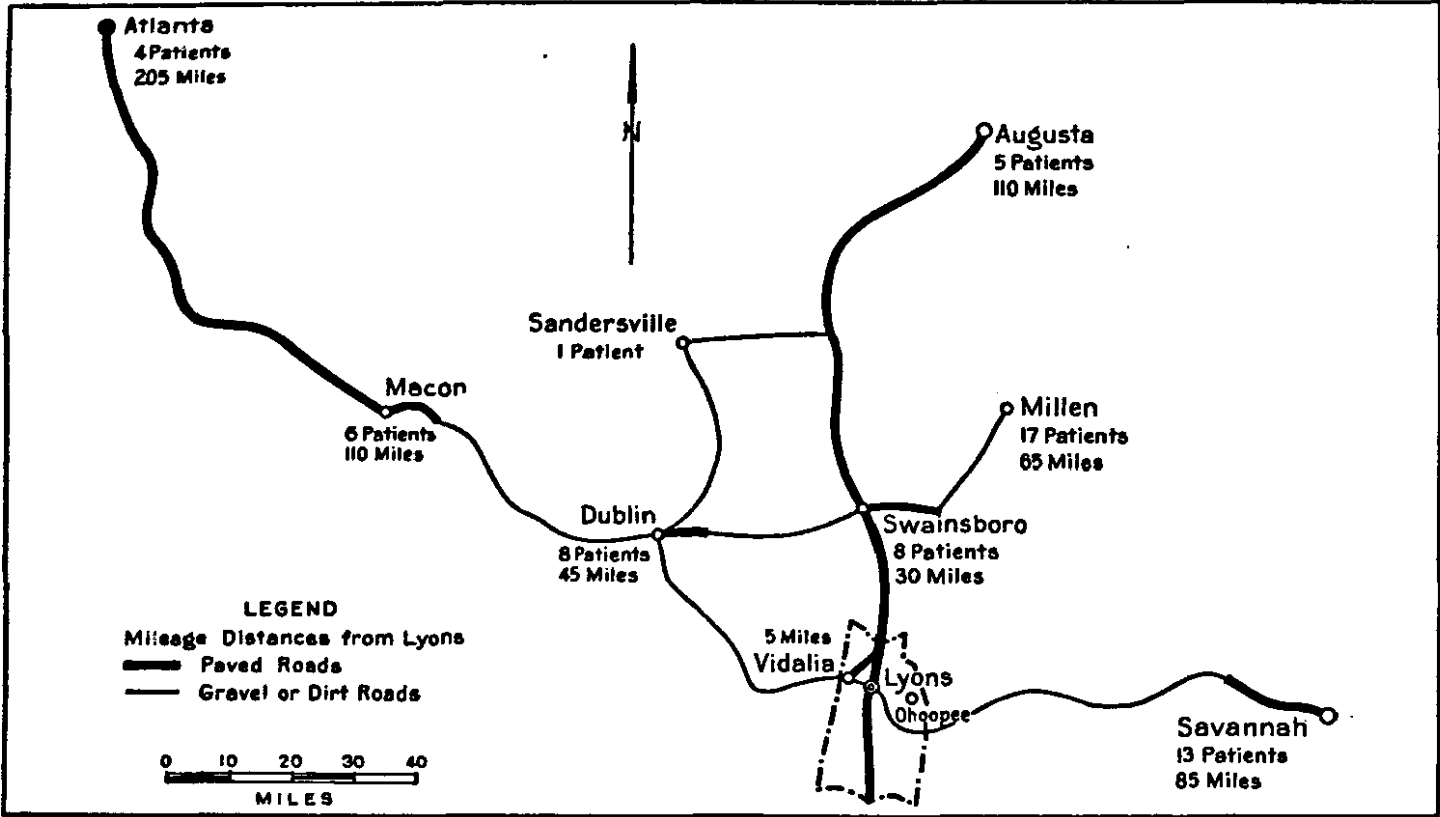


FIG. 15. THE INACCESSIBILITY OF HOSPITALS IN A SOUTHERN COUNTY

This diagram shows that in 1930 four residents of Toombs County, Georgia (the small area surrounding Lyons at the bottom of the diagram) travelled over 200 miles for hospital care in Atlanta, and that other patients travelled the various distances indicated.

objectives which at present seem sound, and to develop definite and purposeful experimental methods of approaching those objectives, preserving, insofar as it is compatible with effective service, the maximum amount of local self-support, and self-control, and the greatest freedom, consistent with social welfare, for the professions and the agencies involved. Although too great decentralization of authority limits competence and threatens economic effectiveness, too great centralization of authority in any plan carries with it elements of ultimate weakness. Fortunately, we have retained in this country a wholesome local responsibility for medical service. This fact means that opportunities exist for trying out many plans under various and variable conditions. Where action can be limited to the city or county, we have several thousand experiment stations. If state action is necessary, there are forty-eight laboratories.

The Committee urges the broadest sympathy toward experimentation in promising fields, together with the most searching analysis of results. Experimentation, however, will be significant only if it is conducted in such a way that its results can be analyzed and made available. Careful records should be kept of all significant financial and qualitative data, in sufficient detail to permit comparative studies. Summaries and comparisons should be prepared and periodically analyzed. The medical records should indicate specifically how much service has been performed, of what kinds, and with what results. Articles describing, in both financial and medical terms, the results of experiments should be published and widely circulated. Constant comparison and study of this kind on a local, state, and national scale is essential to sound progress.

With these considerations in mind, the Committee presents its recommendations. The basic recommendations are few and simple; they seem to the Committee eminently reasonable. All are interrelated, and specific steps are proposed for putting them into effect.

1. ORGANIZATION OF MEDICAL SERVICES

Many of the difficulties in present medical practice can be overcome, wholly or in part, by group organization in medi-

cine. Some of these difficulties are: the lack of coordination between general practitioners and specialists; the isolation of some practitioners from helpful contacts with their confrères and from hospitals and medical agencies; the lack of adequate supervision and control over the quality of some medical care, especially the lack of any effective control over specialization; the enforced idleness of many physicians because of lack of patients; the difficulty experienced by patients in choosing qualified physicians; the unnecessarily large expenditure for overhead costs made by practitioners in individual private practice; and the increasing complexity of medical service which necessitates the use of ever-multiplying equipment, as well as a larger number and variety of subsidiary personnel.

Recommendation 1.—The Committee recommends that medical service, both preventive and therapeutic, should be furnished largely by organized groups of physicians, dentists, nurses, pharmacists, and other associated personnel. Such groups should be organized, preferably around a hospital, for rendering complete home, office, and hospital care. The form of organization should encourage the maintenance of high standards and the development or preservation of a personal relation between patient and physician.*

By an "organized group" the Committee understands a group which is so organized that each professional person in it is responsible to the group for the quality of his work rather than solely to himself.

To carry out this basic recommendation the Committee proposes the following specific steps:

1A. Community Medical Centers.—The Committee's most

* *Dissenting Statement By Committee Member.*—I believe the following should be substituted for Recommendation 1:

"In order carefully to safeguard and preserve the very essential, personal relationship between physician and patient, and to restore the private general practitioner to his rightful place as the key-man in any effective system of rendering medical service, to which his contribution to the profession and to the social order entitles him, we would urgently recommend that every person select a personal or family physician to whom shall be submitted all health problems as well as illness problems; we urge the cooperation of this personal or family physician with available laboratories and specialists, the free use of the services of all such whenever and wherever needed, and the close coordination of such service in rendering adequate and complete medical care. We consider this kind of cooperation better and fairer to all parties, than the organization of professional personnel into partnerships or groups around hospitals or clinics."

This method would be excellent if it would work. The family physician could continue his present functions in much the present method but would utilize extensively diagnostic clinics or state laboratories. However, the trend of the times seems to be against this plan.—Walter R. Steiner.

fundamental specific proposal is the development of suitable hospitals into comprehensive community medical centers,* with branches and medical stations where needed, in which the medical professions and the public participate in the provision of, and the payment for, all health and medical care, with the professional aspects of the service under the control of professional personnel. Existing hospitals may become community medical centers by (1) including general practitioners as well as specialists on their staffs and providing office space for these practitioners, (2) organizing the medical, dental and nursing staffs as a group complying with the essentials of satisfactory medical service set forth in Chapter II, and (3) accepting responsibility for furnishing complete medical service for the local population or for some section thereof. This need not interfere with the reception of other patients. Group clinics may become medical centers through the provision of home service, the addition of hospital facilities or affiliation with an existing hospital, and the formation of a representative community board to counsel and advise the clinic. Industrial and university medical services may expand into medical centers by similar procedures. The services of community medical centers must be coordinated with some plan of group payment. The functions of a community medical center will probably include various clinical, therapeutic, and preventive services which are now often provided by official health agencies. This fact should not, however, impair to any degree the authority, responsibility, or administrative functions of the health department.

1B. Industrial Medical Service.†—Complete medical service paid for jointly by employees and employers embodies a desirable form of organization for medical care if it is developed so that the participating professional men have control over the professional aspects of the service and opportunity and stimulus to maintain high standards. Free choice of practitioners should be allowed insofar as practicable. The Committee suggests that care may often be extended to dependents and that the aim in each case should be to consider the entire family as the unit for which medical service is provided. Suitable means

* This institution is described in Chapter III, p. 59-64.

† For a description of existing industrial medical services see Chapter IV, p. 79-83, Publications No. 5, 18, 20, and Summary Volume, Part VII.

should be found to assure financial stability and some independence of business fluctuations. As a rule, the extension of general medical service to workers and to their families should be confined to those instances where one or more industries are the

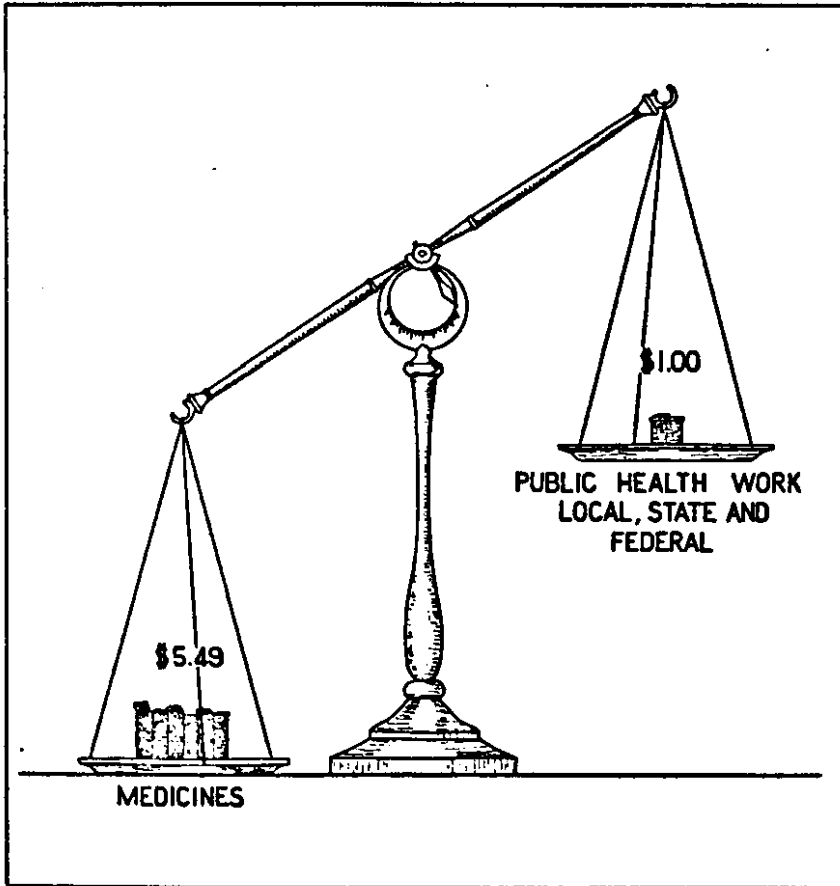


FIG. 16. THE RELATIVE PER CAPITA EXPENDITURES IN THE UNITED STATES FOR MEDICINES AND PUBLIC HEALTH

dominant factor of the community life. In other communities, general medical care should be provided to workers and their families by community medical centers founded on a hospital rather than on an industry. Ideally all industrial medical services should expand into community medical centers, under public and professional control. In such cases the type of medi-

cal service now maintained in most industrial plants, *i. e.*, preventive and sanitary service, should be continued by the factories.

IC. University Medical Service.*—The student health services, found feasible in certain universities, may be extended to other universities and academic institutions, and the services made available on a suitable periodic payment basis to faculty members and their dependents and to other university employees and their dependents. In “college towns” it may frequently be feasible to expand the university medical service into a community medical center which serves townspeople as well as students.

Recommendations for Supplementary or Temporary Use.—In addition to these three recommendations for the organization of complete medical services, the Committee recommends certain other more limited developments. These are:

ID. Utilization of Subsidiary Personnel.—Whatever changes in general organization may be made, the possibility of utilizing partially-trained auxiliary personnel for the performance of the tasks for which they are fitted should be kept in view. There are at least two fields of medical care in which possibilities for economic savings along such lines are obvious:

a. Trained nursing attendants and visiting housekeepers may be utilized for the performance of the simpler nursing procedures and for meeting the exigencies of sickness in the home. Such service should, however, be rendered only under the supervision and direction of fully qualified nurses.†

b. The wider use of trained and supervised nurse-midwives would be of material advantage in the improvement of obstetrical practice.‡ In the more remote rural areas, certainly, great gains would follow the replacement by such trained midwives of the wholly unqualified attendants now in practice. Even in urban areas the more general use of trained midwives in normal uncomplicated deliveries would tend to save the time of the physician and minimize the tendency to resort to surgical interference. Such midwives should be associated with and under the professional direction of competent physicians, where possible.§

* For a description of existing university medical services see Chapter IV, p. 92, Publication No. 19, and Summary Volume, Chapter XXX.

† For a description of the services rendered by nursing attendants see Chapter IV, p. 88, Publication No. 17, and Summary Volume, Chapter XIII.

‡ For a description of services rendered by trained nurse-midwives see Chapter IV, p. 87, Publication No. 16, Miscellaneous Contributions No. 10, and Summary Volume, Chapter XIV.

§ *Additional Statement By Committee Members.*—We believe that the following additional recommendation should be made by the Committee:

“C. We commend the growing tendency in the practice of dentistry toward a division of labor in which a dentist who is also a physician assumes larger responsibilities for the diag-

IE. Private Group Clinics.*—A desirable step in the organization of services is the further extension of private group medical service, independent of public aid, in communities large enough to support this type of service. In time such practice should be expanded to include the services of general practitioners, home care, hospitalization, dentistry, pharmaceutical service, and public health nursing (see II) and should comply with the standards for group practice outlined in Chapter II.

IF. Pay Clinics.†—Patients who are not indigent, but nevertheless are unable to meet prevailing fees, can be helped substantially by the extension and development of pay clinics, which are sponsored and financially aided by the public through voluntary or tax funds. Such clinics should provide adequate remuneration to the personnel, and should delegate control and management of professional aspects of the service to the physicians and dentists concerned. The clinics should be linked closely with the facilities of approved hospitals and should provide home service and public health nursing care (See II). Dentistry, medical social service, and the provision of drugs, eyeglasses, and other appliances should be added as funds permit.

IG. Middle-Rate Hospital Service.‡—The Committee recommends a wider development in existing hospitals of middle-rate programs. Under such programs, the professional staff and the hospital administration organize in a cooperative relationship. A schedule of professional and hospital charges for persons of moderate means is agreed upon, and all charges are collected by the administration. This plan unifies and limits the patient's bill for a hospitalized illness and assists him, after he has become ill, in planning to meet it.

IH. Physicians' Private Offices in Hospitals.—General hospitals may make space available in their buildings, wherein the members of their professional staff may hold office hours for paying ambulatory patients. This plan has already been referred to in Chapter IV as in operation in numerous hospitals. It may be an important step in the direction of associating general medical service with the facilities of hospitals and of assisting in the development of soundly organized group practice.

II. Organized Nursing Service.—Nursing service should be progressively organized in correlation with the organization of medical services and of public health activities. The private duty nurse, practicing individually, occupies a position of increasing economic insecurity. So rapid has been the growth in the number of nurses that there are far more private duty and institutional nurses than can be employed under present circumstances. Yet the needs of the people if fully supplied would call for all the nurses. This situation is an excellent illustration of the distinction between need and demand. The barrier is primarily—although not exclusively—an economic one. This is evident

nosis and treatment of conditions arising from or related to the teeth, while much of the routine performed by the dentist in the past is delegated to dental hygienists and other technicians working under his direction."—Morris L. Cooke, Haven Emerson, Mrs. Walter McNab Miller, Alfred Owra, William J. Schieffelin, John Sundwall, C.-E. A. Winslow.

* For a description of existing private group clinics see Chapter IV, p. 76, Publication 8, and Summary Volume, Chapter XXV.

† For a description of existing pay clinics see Chapter IV, p. 84, and Summary Volume, Chapter XXVI.

‡ For a description of middle-rate hospital service see Chapter IV, p. 83, Publication No. 4, and Summary Volume, Chapter XXVI.

from the contrasts between the nursing services received during a year by families of different income levels (Table 3). To overcome the economic barrier, nursing service should be one of the important services provided on a group payment basis by the organized medical groups described above (especially in Recommendations 1A, 1B, and 1C). Home nursing service on an hourly or visit basis should also be more widely provided by organized agencies in cities and particularly in small towns and rural areas, most of which are now without organized nursing care. Since it is desirable for the services of visiting nurses to be unified for a particular area, organized medical groups should, where possible, arrange for the provision of home nursing through existing organizations, rather than attempt to provide new machinery. Provision should also be made for a subsidiary licensed personnel, working under supervision, capable of furnishing housekeeper service in the home and attendance upon the sick. All organized nursing service given in the home either should be under the direction of the public health nursing organization of the community or should cooperate with it.

1J. County Medical Society Clinics.*—In rural areas or small towns, county medical societies may establish clinics to provide care for persons unable to pay the current fees of private practitioners. These clinics should be paid by the county or city authorities reasonable sums for their services.

Discussion of Recommendations Regarding Group Practice.—Certain aspects of these recommendations require further discussion.

Scope of Groups Envisaged.—The major recommendations regarding group practice envisage groups providing *all* the needed therapeutic and preventive medical services except care for tuberculosis, mental disease, or other conditions which have been accepted as governmental responsibilities. Thus complete groups would contain physicians, both general practitioners and specialists, dentists; nurses, pharmacists, medical social workers, and all the needed technicians and assisting personnel. Under particular circumstances, it may be desirable temporarily to omit one or more types of service, or to arrange for its provision by separate but cooperating organizations. It is equally clear that many groups in smaller cities and towns cannot afford the full-time services of specialists in each branch of medical practice. To obtain the less common specialized services these groups should affiliate with larger centers, particularly with teaching hospitals and medical schools.

Control and Better Use of Specialists.—The extension of properly organized group practice will be of substantial as-

* For a description of county medical society clinics see Chapter IV, p. 74.

sistance in solving the professional and economic problems of specialization. The practice of specialties has been ill-defined in the United States, and there has been relatively little control over those who wished to be considered as specialists. Standards for specialists should be developed by the appropriate professional bodies, and the general public should be educated in the more discriminating use of specialists, and the economy of time and money which results from reliance on the well-trained general practitioner.

Under group practice the specialist finds a place in professional service which relates him properly to his professional colleagues in general medical service and in other specialties. The patient gains not only the convenience and economy of consulting all needed specialists at one place instead of in a number of separate offices, but also the more important advantage of obtaining advice which represents the concerted judgment of whatever specialists his needs may have required, pooled and organized for him by his family practitioner. Often today the patient obtains a number of independently rendered opinions from specialists and acts as his own interpreter.

Association with a group enables the young physician better to use his time and helps to enlarge the scope and responsibility of his work in accordance with his capabilities and experience.

Maintenance of Quality.—The development of group practice carries serious hazards. The most serious of these is that the quality of medical service may be adversely affected, either through the internal arrangements of the group, or through the relations between one group and others.

It is sometimes said that there is an inherent antagonism between group organization in medicine and the needed personal relation described in Chapter II. It is true that much group practice is not only organized but also institutionalized. This, however, is not necessary. There is evidence that it is practical to organize a medical group, so far as the patient is concerned, with the family practitioner as its center.* The patient can choose among available groups and among the family practitioners in each group; and the physician of his

* See footnote on p. 46.

choice can approach the ideal family physician in a far higher degree than is now generally achieved.

It is claimed that group organization will lessen what Sir Arthur Newsholme calls "that spirit of adventure which is indispensable for the development of virile and moral humanity." Practitioners in groups do not run the same economic risks that those in individual practice run. They suffer or prosper with the group. Undoubtedly some of the independence and initiative of individual practice is lost. On the other hand, group practice brings new stimuli and wider opportunities for professional advancement. Constant association with colleagues is, in itself, a broadening educative process. Moreover, opportunities for postgraduate study can be made available under group organization to thousands of physicians who now are unable to leave their work for more than very brief periods.

The quality of group practice may also be affected by competition among groups and between groups and individual practitioners. In the interests of both consumers and producers, it is desirable that the conditions of competition shall be "fair"; that is, that the service provided be efficient, economical, and of good quality, and that the remuneration to those providing it be adequate. As a rule, private practitioners now spend about 40 per cent of their gross income in meeting overhead expenses, but groups can lower this percentage substantially, without lessening professional net incomes or impairing the quality of service. Undoubtedly this fact puts the individual practitioner at a disadvantage. Yet it is so patently in the interest of society to eliminate this unnecessary overhead that such competition is not "unfair." With the extension of group practice, however, this competition would affect only those physicians who would not or could not become associated with groups. The control of "unfair" competition is discussed under Recommendation 3.

Relation of Medical Groups to the Public.—"A profession," according to the Code of Ethics of the American Medical Association, "has for its prime object the service it can render to humanity." The interrelations of the public and the medical professions are numerous and close. The respective responsi-

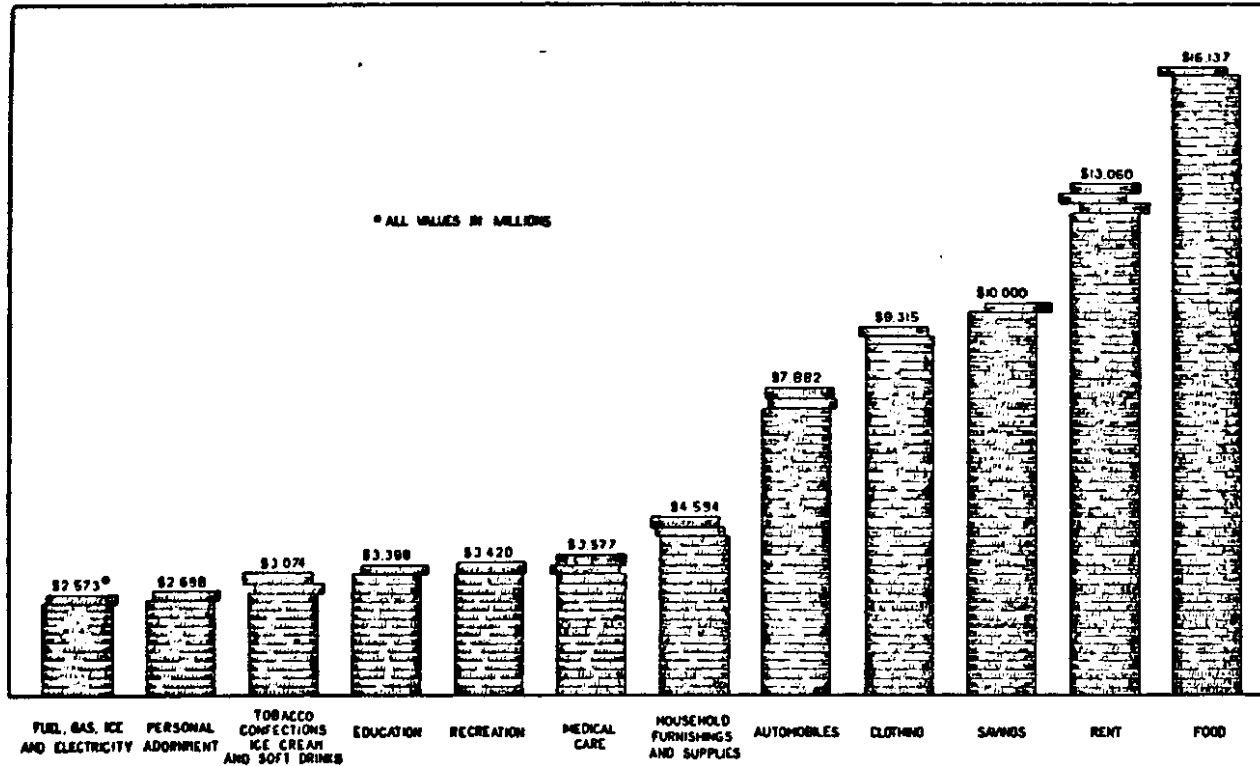


FIG. 17. THE PLACE OF MEDICAL CARE IN THE NATION'S EXPENDITURES

The amounts of money spent by the people in 1929 for various purposes (all items of over \$2,500,000,000 are included). The amounts for education and medical care include governmental as well as individual expenditures. The figure for medical care is lower than the figure of \$8,656,000,000 given elsewhere in this report since the \$79,000,000 spent by industry is not included. "Savings" are not strictly comparable with the other items. Included in the figure for savings are: life insurance (the net increase in the assets of life insurance companies), savings deposits, and the purchase of securities. Corporate savings are not included. The estimate for "Savings" is a very rough one.

All these expenditures represent the direct outlays of consumers as such, *i. e.*, expenditures for business purposes are not included.

bilities of the two groups were clearly indicated by the British Medical Association when in 1930 it presented its proposals for a general medical service for the nation:

The Association therefore presents the following scheme to the public and invites the fullest criticism. Such a scheme may be compared to a plan submitted by an architect to a householder who wants to extend the house in which he lives and to introduce all modern improvements. The householder may, on seeing the plan, decide that it would cost too much and that he must put up with his house as it is; or he may make suggestions for the modification of the plan. But the householder knows that if he wants to extend his house he is, as regards essentials, in the hands of the architects and builders.

2. THE STRENGTHENING OF PUBLIC HEALTH SERVICES

The United States spends only \$1 per capita for public health services to every \$29 for other medical services. As a consequence public health service in the United States—both governmental and non-governmental—is far from adequate, even in many large and medium-size cities. In towns and rural areas it is usually rudimentary. Public health work does not attract so many well-qualified medical students as it should, because tenure is frequently uncertain and subject to political influence and because lack of adequate financial support often makes the remuneration low and restricts the opportunities for effective work. Considering its potentialities for raising the general level of health of the people at relatively low cost, the public health service in the United States is very deficient.

Recommendation 2.—The Committee recommends the extension of all basic public health services—whether provided by governmental or non-governmental agencies—so that they will be available to the entire population according to its needs. Primarily this extension requires increased financial support for official health departments and full-time trained health officers and members of their staffs whose tenure is dependent only upon professional and administrative competence.*

Accepted public health services should be extended, under full-time trained health officers employed by local or state governments, to all areas which are now without such services, as

* In making this recommendation the Committee has in mind primarily the public health services performed by health departments. However, the health service of other governmental agencies, such as education and welfare departments, and of voluntary agencies are also community public health activities and should be ably conducted and closely linked with the work of health departments.

rapidly as qualified personnel are available. The tenure of health officers and their staffs should be independent of political considerations, and should depend entirely upon administrative and technical competence. Approximately \$2.00 to \$3.00 per capita should be allowed local health services to enable them to meet accepted standards, such as those of the American Public Health Association. The area for a public health unit should be sufficiently large and populous to make such support feasible. This will often require in rural communities the joining of several counties or other governmental units in a public health district.

In addition to geographic extension, public health services should be expanded until they include all the types of service which are proper public health functions, unless these services are adequately supplied by non-governmental agencies cooperating with the health department. There is nearly universal agreement that the following are "proper public health functions": (a) the collection and analysis of vital statistics; (b) the control of water, milk, and food supplies; (c) the control of sanitation; (d) the control, through quarantine and supervision, of communicable diseases; and (e) the provision of laboratory service. In addition to these, the Committee believes that the following activities are also proper public health activities: (f) the promotion of maternal, infant, and child hygiene, including medical and dental inspection and supervision of school children; (g) popular health instruction; (h) the provision of preventive dental care for children, and (i) the provision of special services for the prevention, diagnosis, and treatment of patients with tuberculosis, venereal diseases, malaria, hookworm, or any other disease which constitutes a special health problem in the community that cannot be solved adequately and effectively by the other available medical and health agencies. For many of these services, it is essential to have a well-organized and efficient public health nursing service. The Committee is aware that the particular public health activities which most need expansion differ from one community to another. Careful study should be given to all public health work to insure a balanced community program.

3. GROUP PAYMENT FOR MEDICAL SERVICE

The costs of medical care, as was shown in Chapter I, fall very unevenly on different families in any one year and on the same family in different years. It is impossible to budget such costs accurately on an individual family basis. For the low-income families, who constitute the great majority of the population, not only are present expenditures uneven and unpredictable, but they are also much too low in total to provide adequate medical service. The population as a whole, however, except in "hard times," can pay for adequate service without hardship. In fact, to a certain extent good medical service pays for itself in prevention of disease and in increased efficiency and productive ability.

Recommendation 3.—The Committee recommends that the costs of medical care be placed on a group payment basis, through the use of insurance, through the use of taxation, or through the use of both these methods. This is not meant to preclude the continuation of medical service provided on an individual fee basis for those who prefer the present method. Cash benefits, *i. e.*, compensation for wage-loss due to illness, if and when provided, should be separate and distinct from medical services.

Except for some of the members signing the minority reports beginning on page 151, the Committee agrees to the principle of group payment for meeting the expenses of medical care. The methods of utilizing this principle, however, are numerous. They vary with the type of community, the social and economic groups to be served, and the scope of medical service to be provided. Hence, a number of specific steps are recommended. Some of these could be introduced promptly, as local experiments. Others, particularly the recommendation for required health insurance (3B), involve broad public policies and legislative action. Eight members endorse Recommendation 3B as a desirable and opportune step for certain states within the immediate future. The other members either do not consider it desirable in principle or believe that it should be approached only after adequate experience with other developments in group practice and group payment. These different points of view are presented in the discussion on page 124 *et seq.*

3A. Voluntary Cooperative Health Insurance.*—The Committee recommends that organized groups of consumers unite in paying into a common fund agreed annual sums, in weekly or monthly installments, and in arranging with organized groups of medical practitioners working as private group clinics, hospital medical staffs, or community medical centers, to furnish them and their families with virtually complete medical service. By “organized groups of consumers” the Committee means industrial, fraternal, educational, or other reasonably cohesive groups.

3B. Required Health Insurance for Low-Income Groups.†—Some members of the Committee ‡ believe that the industrial states at least should immediately begin to plan for the adoption of legislation which will require all persons in certain income groups, certain occupations, or certain areas to subscribe for health insurance.

3C. Aid by Local Governments for Health Insurance.—If a community relies for the provision of medical service primarily upon the purchase by its people of voluntary health insurance, as described in Recommendation 3A, it will doubtless find that part of the people because of their low incomes cannot pay, even on a periodic basis, the full cost of complete service. Such communities may well use tax funds to the extent necessary to supplement the payments of these low-income families. Most members of the Committee believe that it is important for each individual or family which receives medical service to make, if possible, some definite personal payment for that service, according to its means, even though the payment may be considerably less than the full cost. When health insurance is required by law, it may also be necessary and desirable that a contribution be made from government funds.

3D. Salaried or Subsidized Physicians in Rural Areas.§—The Committee recommends that rural areas or those of low economic resources, where suitable medical service is not now obtainable at a reasonable cost, should subsidize physicians or

* For a description of cooperative health insurance without legal compulsion see Chapter IV, p. 94, and Summary Volume, Chapters XXVIII-XXXI.

† For a description of foreign experience with required health insurance see Chapter IV, p. 96.

‡ See list given on p. 130.

§ For a description of salaried physicians in rural areas see Chapter IV, p. 99, Publication No. 11, and Summary Volume, Chapter XXXII.

employ salaried physicians to furnish general medical service to residents of the area. Where the economic condition of the community permits, hospital service, public health nursing, dentistry, pharmacy, and occasional visits of specialists may be provided on the same financial basis and in coordination with the physicians' work. For the support of a local hospital, and, in certain instances, for other services, it will often be desirable, even necessary, for two or more counties of this type to join forces. Such a hospital may become a small medical center and should affiliate, if possible, with a large nearby general hospital or community medical center. Where only one physician is available in the area, he may also be the local health officer.

3E. State and Federal Aid.*—For communities with such low per capita incomes that local tax funds are insufficient to supplement the payments of individuals and groups of patients, the Committee recommends state financial aid. In such cases the state should insist on the maintenance of reasonably high standards for the medical service.

In the less prosperous sections of the country, particularly those areas where pellagra, hookworm, malaria, typhoid fever, and tuberculosis raise the morbidity and mortality rates, and where the people have pitifully small money incomes, the Federal government should enable state and local governments to provide a basic minimum of good medical care.

In general, a majority of the Committee believe that it is wise never to rely on a larger unit when the cost can be borne by a smaller one. The community should not be called upon if the family can carry its own burden. The state should not be called upon if the community can meet the cost. The Federal government should not be asked to contribute if the state can pay its way. Where the smaller unit is economically unable to bear the entire burden, however, the larger unit must be ready to aid.

Recommendations for Supplementary or Temporary Use.—In addition to the foregoing five major recommendations, six others are presented.

* For a description of state and Federal aid see Chapter IV, p. 91, and Summary Volume, Chapter XXXII.

3F. Voluntary Hospital Insurance.*—The Committee recommends that, in the absence of a more comprehensive plan, general hospital service, not maintained by taxes or designed primarily for the wealthy, should be provided wholly or in part on a voluntary insurance basis, individuals or groups in the community paying agreed annual sums and receiving hospitalization when needed without further charge. Such plans will be of wider social benefit if they cover professional fees for hospitalized illness, as well as the charges for hospitalization itself. If there is more than one hospital in a community it will frequently be desirable for all the hospitals to enter a cooperative hospital insurance plan.

3G. Tax Funds for Local Hospital Service.†—The Committee recommends that, where hospital facilities are lacking or inadequate, cities and counties use tax funds to provide hospital service, either through the construction of new hospitals or the extension of existing, well-managed institutions. Practitioners in such hospitals should be remunerated by the patients or by the community. In communities which are adequately supplied with hospital service, the Committee recommends that local and state tax funds be used to reimburse voluntary, non-profit hospitals which maintain good standards for all or part of the costs of service to patients who cannot meet their own expenses and who are not included in insured groups.

3H. Tax Funds for Medical Care of Indigent and Neccessitous.—General medical care for those who are charges upon the community must be provided either by private charity, including the charitable services rendered by practitioners, or by public funds. The Committee believes that this burden should fall largely upon the latter and recommends that more adequate provision be made for meeting it. The service should include medical, dental, and nursing care, given in hospitals, clinics, or homes. Sound public policy demands that the practitioners as well as the agencies which provide such service be properly remunerated.

* For a description of voluntary hospital insurance see Chapter IV, p. 81, and Summary Volume, Chapter XXXI.

† For a description of tax funds for local hospital service see Chapter IV, p. 89, and Summary Volume, Chapter XXXII.

*31. Public Support for the Care of Chronic Diseases.**—The Committee recommends adequate tax appropriations from local and state governments to insure hospitalization and other medical service for patients who are suffering from tuberculosis, mental disease, venereal disease, arthritis, and other chronic conditions, in so far as these patients are unable to provide suitable care from their own resources. The community payments may be used to support either governmental or non-governmental organizations.

Discussion of Recommendations Regarding Group Payment.—None of these recommendations involves an untried experiment. All the proposed methods have been extensively tested, nearly all of them in the United States. Many of them the Committee has studied in actual operation. To clarify their implications, however, further discussion of them is desirable.

Voluntary Cooperative Health Insurance.—This proposal is relatively new in the United States, although numerous organizations are now providing medical service on this basis. Some of them have been described in the Committee's reports.

Voluntary cooperative health insurance, as visualized by the Committee, requires the development of a community medical center or some less comprehensive form of group practice. Most payments for service, however, would be made to this center or group on an agreed periodic basis by groups of potential patients, rather than by individuals according to the services which they receive. The plan is flexible, however, since the same group of practitioners might render service to some patients on an insurance basis, to others on a fee-for-service basis, and to indigent persons in return for payments in full or in part from governmental or charitable bodies. Some of the professional men in such a group might continue to serve their former private patients, for a time at least, on the customary fee basis.

A state medical society might initiate and standardize the organization of group practice in local areas and serve as a negotiating or mediating body in making the arrangements for group payment.

* For a description of public support for the care of chronic diseases see Chapter IV, p. 88.

Such voluntary cooperative health insurance is far superior to the old type of "lodge practice" in which a single physician was engaged, frequently at an utterly inadequate salary, to serve the members of the lodge. Under this proposed plan, the service would be rendered by a well-organized group of practitioners with an established public position in a hospital or clinic. The professional aspects of service would be under the jurisdiction of the professional personnel, and they would have a definite opportunity and procedure for presenting their points of view on non-professional matters, such as finances or questions of public policy, to the trustees or directors of the institution. Such organized practitioners would be better able to render good service and to protect their professional standards and financial interests than an individual physician when separately employed on a part-time or full-time salary.

Certain defects, however, have developed in some existing plans of voluntary health insurance. In those areas in the United States where an incomplete form of this plan has been tried extensively, some groups of practitioners have been willing to cut their fees and to impair their service in order to attract patients from other groups. Some clinics have employed practitioners at inadequate salaries and have loaded them with more work than they could possibly do well. Certain clinics have consumed an excessive share of the income of the group for personal purposes, leaving little or no reserve to meet emergencies or to provide for needed expansion of service.

These dangers would be obviated in part if all voluntary health insurance were offered by community medical centers, with financial control by representatives of the public and professional control by participating practitioners. Further safeguards could be erected if state or national medical and dental societies formulated standards for the organization of group practice and set minimum fees for group purchase arrangements of various types. Each medical group which offered voluntary health insurance could then be inspected and graded, as hospitals and medical schools are now graded by national, professional organizations.

In order to maintain quality of service and the needed personal relation between patients and physicians, the organiza-

tion of practitioners furnishing the service should comply with the standards suggested in Chapter II.

Arrangements could be made between a community medical center, a hospital staff, or a private group of physicians, and an organized body of employees, or the members of an educational, fraternal, or social organization in the locality. If only insured patients were accepted, at least 5,000 members would be necessary and 10,000 or more would be better. A smaller number could not support a sufficient number of physicians to give the advantages and economies of group practice and to include the needed specialties. Frequently the professional men of a group will already be practicing in the community and the annual payment arrangement will supplement this existing practice. Under these conditions, a group as small as 1,000 or even 500 insured persons might, perhaps, be accepted. The number, in such cases, is less important than that the group have only an average number of sickly individuals.

Some stable and effective organization for handling financial details is necessary. This work might be undertaken by the organized medical group, though often industrial employers and other agencies will make collections and disbursements and keep the accounts with the subscribers. The nucleus of insured persons should be a group already organized in order to prevent an undue proportion of sickly persons and to reduce administrative costs. In initiating such a plan, the existing organization of potential members should discuss the proposed plan and agree to it unanimously or by majority.

A private group of physicians or a community medical center, once having started such a plan with an organized group of patients of fair size, can add much smaller groups and, with certain restrictions designed to avoid adverse selection, can even accept individuals. The latter would be charged slightly higher fees because of the additional administrative cost and the risk that their medical needs might be above the average.

As complete medical, dental, and nursing service as possible should be provided; but in practice the scope of service cannot exceed that which the insured persons demand and can purchase.

This plan is applicable only to communities where groups of consumers and of practitioners are already organized. It is,

therefore, chiefly applicable to cities or industrial areas. Even here it can reach only a certain fraction of the population. If, however, the dependents of employees are included, and if small groups and individuals are subsequently added, a large part of the local population might be served.

Families with low or irregular incomes, even if they are self-supporting while employed, cannot usually be covered by any form of voluntary insurance. The experience with voluntary insurance in other countries has generally led to the conclusion that persons employed in small businesses or self-employed are also unlikely to enter a voluntary plan, unless they see a saving to them personally or a likelihood of better care. For these reasons, voluntary health insurance has been succeeded by compulsory insurance in most of the countries of western Europe.

The use of the state's power of making membership in a sickness scheme obligatory for large groups of persons increases the population served and also reduces the administrative cost of securing and retaining members. The Committee recognizes that the distribution of the costs of medical care will not become widespread in some communities, or for certain sections of the population in many communities, unless there is legislation which makes the distribution of these costs compulsory.

The majority of the Committee, although aware of the limitations of coverage and the possible difficulties of voluntary health insurance, nevertheless believe that the ultimate results will be far better if experience with actuarial and administrative details, and above all the evolution of group practice units capable of rendering rounded medical service of high quality, precede the adoption of any compulsory plan by a state as a whole.*

* *Comment By Committee Members.*—We call attention to these significant statements embraced in the body of the report: "Fortunately we have retained in this country a wholesome local responsibility for medical service. This fact means that opportunities exist for trying out many plans under various and variable conditions. . . . The Committee urges the broadest sympathy toward experimentation in promising fields, together with the most searching analysis of results." We believe that experimentation along the lines of both voluntary and required health insurance, along with the other experiments in the group purchase of medicine should be promoted and carried on. In all likelihood, in certain areas of the country and for certain population and economic groups, required health insurance will be found to be more feasible and practicable than voluntary health insurance or vice versa. (*Conf. on p. 122.*)

Their reasons for holding this position are:

The maintenance of the quality of medical care is fundamental. Good service to the sick is worth what it costs; poor service is likely to be worth little or nothing. It is much more important to establish plans whereby complete and competent medical care will be obtained by a considerable section of the population, and later, on the basis of this experience, to work out ways and means of extending the same care to all, than to devise a more widespread plan which would furnish a medical service limited in scope and deficient in quality. In the main, foreign systems of compulsory health insurance have done the latter. The scope and quality of their services have improved with time, but America need not follow their mistakes either in policy or method. It is probably true that in the United States, except for some rural areas, a much larger amount of medical service is available, and is actually obtained even by low-wage-earners, than was the case in any European country during the period when its health insurance system was developing. A plan which was aimed especially to bring in the low-wage-earner and which was keyed down to his paying ability, would either have to be subsidized from the start by employers, by tax funds, or by both, to an unprecedented degree, or else it would provide a medical service more limited in scope or lower in quality than a large part of the population now receives.

European practice has no doubt moved on from voluntary to compulsory insurance; but the former appears to have represented a desirable preparatory phase. To many members of the Committee, experience of European countries suggests that a certain development of voluntary insurance may be inevitable before the people of a country become sufficiently familiar with the principles involved to support adequately any legal requirement for insurance.

It is very desirable to develop strong, organized professional groups, each rendering comprehensive medical service, before insurance becomes compulsory. If health insurance is to operate most successfully, it must cover all forms of illness and

Therefore, we feel that the report should not emphasize or recommend voluntary health insurance over required health insurance, or vice versa, but that both plans or a combination of the two be equally recommended by the Committee for experimentation.—Haven Emerson, Mary M. Roberts, William J. Schieffelin, John Sundwall, Henry C. Taylor.

include preventive as well as therapeutic care. Such an end can be attained more readily when the medical service is rendered by organized groups than when rendered by individual practitioners. Unless there has been ample previous experience in a state with group practice as a basis of furnishing medical service, any law for required health insurance would make individual practice and not group practice the legal foundation of the whole system. Such has been one of the chief disadvantages which European countries have faced under compulsory insurance. In Germany the recent trend toward group practice has been seriously hampered by the compulsory insurance law.

There are also weighty administrative considerations against making health insurance compulsory as a general program for the United States. Compulsory insurance abroad has depended for its administration largely upon organized groups of employees, such as unions or cooperative societies. Their part in the administration has in some countries proved disadvantageous to quality and economy of service, partly because of the wide geographical dispersion of the membership, and partly because health insurance is likely to be a secondary interest of these organizations. Be this as it may, such industrial and cooperative associations are not sufficiently developed in most localities in the United States to include more than a small fraction of the population. It would be impossible, therefore, to use such organizations as the basis for administering compulsory health insurance. Usually it would be necessary to form new, local organizations. This would require a large amount of direct governmental administration, because the government would be the only available or recognized agency, capable of administering a compulsory insurance plan for the diverse and unorganized elements that make up the population of most American cities. European experience, particularly in those countries like Germany and Austria which have had comprehensive insurance plans for many years, shows that serious evils of competition and price-cutting may exist under a compulsory plan and, if so, are difficult to eradicate.

Finally, it is probable that no legislature would pass a compulsory health insurance law unless it included, from the start, a combination of medical care insurance with cash bene-

fits for income protection; but these two forms of insurance should not be combined.

For these reasons the majority of the Committee does not endorse the recommendation (3B) which would make health insurance a legal requirement for certain sections of the population. These members realize that such a step may ultimately be necessary and desirable in some states, but they believe that for most states and probably for almost all of them at the present time, it is much more desirable (a) to encourage voluntary measures for protection against wage loss during sickness, and (b) to develop voluntary insurance for medical care in conjunction with group practice, with hospital service and with the related measures recommended on the preceding pages. They are of the opinion that the difficulties of these plans can be controlled by a combination of professional and community effort, and that these plans hold the promise of steady extension in scope of service and in proportion of the population served. These members believe that the various payment plans (aside from compulsory insurance) * if fully carried out, would: (1) largely solve the problem of hospital costs which constitute about 50 per cent of the average family expenditure for the care of sickness; (2) provide adequately for many rural areas in which serious deficiencies of facilities exist at present; (3) make more nearly adequate provision than exists at present for the "indigent" and for the care of certain diseases of public importance; and (4) provide, through voluntary cooperative insurance (Recommendation 3A), medical service to a majority of the 70,000,000 people living in industrial communities and in cities.

Required Health Insurance.—Those members of the Committee who subscribe to Recommendation 3B for legally required health insurance † believe that such health insurance

* These "various payment plans," it will be remembered, include, in addition to voluntary cooperative health insurance, the following: aid by local governments for health insurance, salaried or subsidized physicians in rural areas, state and Federal aid for local communities, voluntary hospital insurance, tax funds for local hospital service, tax funds for medical care of the indigent, and public support for the care of chronic diseases.

† William Darrach, Homer Folks, William T. Foster, William F. Ogburn, Elizabeth Fox, Alfred Owre, Amelia Sears, Winford H. Smith.

Editor's Note: In addition to these members of the majority group who subscribe to compulsory health insurance, two members of the first minority group subscribe to it (Drs. Howlett and Wilson, see p. 168), and Professor Hamilton states that this "is the very minimum which the Committee should have recommended." (See p. 196.)

will eventually be necessary and that it is unnecessary and perhaps even undesirable to encourage a voluntary system. They take this position for the following reasons:

1. Most European countries, one after another, have gone from a voluntary to a required system of insurance, but many of the evils of the voluntary system are carried over to the compulsory plan. Vested interests are built up under voluntary insurance which are very difficult to dislodge, even though they seriously hamper effective work. While it is true that the United States has few cooperative societies which could administer compulsory health insurance, this is a fortunate rather than an unfortunate circumstance. In European countries, such societies have almost completely outgrown their usefulness, so far as health insurance is concerned; but they still remain to clutter and confuse administration, and to prevent insurance statistics from being useful for public health purposes.

2. Voluntary insurance will never cover those who most need its protection. No legerdemain can bring into a voluntary system the unorganized, low-paid working group who are not indigent but live on a minimum subsistence income. Yet any plan that helps those with less serious needs and does not reach those whose needs are sorest does not solve the fundamental problems of providing satisfactory medical service to all.

3. There is no innate antagonism between required health insurance and the development of organized medical service. On the contrary, such health insurance might be a powerful stimulus to the formation of organized groups. If health insurance covers all major types of medical service, and if local communities are free to obtain medical service from organized groups, when such groups are available, the obvious benefits, economic and professional, of organized service will act as the most effective possible stimulant to the formation of such groups. The dangers of giving local communities this authority can be guarded against if all contracts are subject to approval by a state board that insists on fair treatment to the practitioners and the maintenance of good standards.

4. Required insurance will undoubtedly be simpler and more direct to administer and, in the long run, more economical. There will be less tendency to create over-lapping agencies and

to duplicate capital investment. Because a large proportion of the people will be included, it will be more stable.

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

Medical Service in Rural Areas.—The plan for medical service in rural areas or areas of low economic status which is recommended in 3D has been used in two Canadian provinces to the general satisfaction of practitioners and patients,† and is, doubtless, adaptable to conditions on this side of the border. For the people of such districts, it is necessary and proper, the Committee believes, for state and, perhaps, Federal funds to be used to match or supplement local tax funds.

Hospital Insurance.—Although fewer than 10 per cent of the population are cared for in hospitals in any one year, hospitalized illnesses are so expensive that they consume 50 per cent of the total annual expenditures for all medical care. Of this amount, 39 per cent is paid to the hospitals, 45 per cent to physicians, 8 per cent to special nurses in the hospitals, and 8 per cent for other services or supplies. Hospitalized illnesses, which cost, on the average, \$140 per case, bear with special weight on those persons in the so-called "middle classes" who can ordinarily meet the costs of minor, brief or non-hospitalized illnesses, but who cannot pay much more.

To protect families against all the financial hazards of high-cost illnesses, however, insurance against the cost of hospitalization alone will be insufficient since the costs for the hospital, the physician, the dentist, and the nurse all share in the creation of high-cost illnesses. Insurance which includes also the professional fees for hospitalized illnesses would more nearly, although not completely, solve the problem of high-cost illnesses.

Nowhere in this country or abroad are the entire costs of hospitalization for the whole population above the level of

* *Additional Statement By Committee Members.*—We believe that an additional reason for the early adoption of required health insurance rather than voluntary insurance is that a system of required insurance encourages the development of higher standards of medical care of the patients included in such a system.—William Darrach, Homer Folke, William T. Foster, Elizabeth Fox, Wesley C. Mitchell, Alfred Owre, Winford E. Smith, John Sundwall.

† Publication No. 11.

indigency met from patients' fees or insurance payments. The principal supplementary support is from tax funds. The Committee's recommendation for the extension of tax support (3G) does not imply that governmental institutions shall replace voluntary general hospitals but merely that tax funds shall be used to build supplementary institutions or assist existing ones. The extension of hospital insurance and of tax support could well go hand-in-hand, each method supplementing the other.

Costs of Proposed Medical Service.—Whether health insurance is offered on a voluntary or a required basis, it could probably be provided for about \$1.50 to \$3.25 per adult wage-earner, per month, with somewhat lower rates for dependents. Required insurance would probably cost somewhat less than voluntary insurance, since there would be no danger of an undue proportion of sickly persons and the administration would be simpler and more direct. The maximum figure, \$3.25 per month, while not greatly higher than present average per capita expenditures, could provide service of substantially larger volume and better quality than the wage-earning population now usually receives, and could furnish funds for adequate remuneration of practitioners. This could be effected mainly by redirection of expenditure and reduction of waste.

Professional Standards.—The Committee believes that all the recommended plans of group payment can be administered in accordance with high standards of professional service and with adequate compensation for practitioners and hospitals. Some of the recommendations, it is true, involve what is called contract practice,* but the Committee does not believe that this necessarily will injure the personal relation between physician and patient.† Practitioners can be remunerated according to whatever plan is best adapted to maintaining their effective-

* The Judicial Council of the American Medical Association defines contract practice as "The carrying out of an agreement between a physician or group of physicians as principals, or agents, and a corporation, or organization, or individual to furnish partial or full medical services to a group or class of individuals for a definite sum or for a fixed rate per capita."

In the opinion of the Committee, the existence of contract practice is evidence of an effort on the part of the people and the profession to develop service on an annual payment basis, and its frequent failure to meet needs has been due to inadequate control of quality of service and to destructive competition.

† For a discussion of the character and significance of the personal relation see Chapter II, p. 39-41.

ness. The use of funds either from insurance or from taxation does not necessitate any particular method of remuneration for practitioners. While salaries will doubtless be the most frequent method in group organizations, some groups have successfully employed a fee-for-service system, a capitation system, a proportional division of receipts, or various combinations of these. The group of practitioners furnishing service will in many instances themselves determine the distribution of the funds available for professional remuneration.

Control of Competition.—The control of undesirable or “unfair” forms of competition is important to both the professional groups and the groups of insured persons. The former will suffer if rates of remuneration are forced below a reasonable scale, or if conditions of work are inimical to professional freedom or efficiency. The latter will suffer if the quality of service is poor and, under such circumstances, their money will be largely wasted. Control of competition may be sought through the following devices:

(a) Provision of medical service in increasing proportions by organized non-profit groups with community backing and control.

(b) State regulation of the finances to assure actuarial soundness.

(c) Formulation of general standards and policies, regulation of charges, and arbitration of difficulties by the state medical and dental societies or by an officially appointed medical board nominated in large part by the societies.

4. COORDINATION OF MEDICAL SERVICES

One of the principal defects in the present-day provision of medical services is that there is, in most communities, no competent agency to evaluate, supplement, and coordinate the medical services of the community on the basis of unbiased and thorough knowledge. As a consequence, some communities lack various important services, while at the same time they have an oversupply of other facilities or personnel. Some practitioners or agencies are inadequately utilized while others are overburdened.

Recommendation 4.—The Committee recommends that the study, evaluation, and coordination of medical service be con-

sidered important functions for every state and local community, that agencies be formed to exercise these functions, and that the coordination of rural with urban services receive special attention.

This proposal could and should be put into effect in all states and most cities in the immediate future. The following specific steps may be adopted to give effect to this recommendation. The first is a temporary measure to promote immediate action; the second and third are permanent devices which complement each other:

4A. Temporary Professional Groups with Lay Participants.—In order to initiate a progressive program for cities, counties, or states, the appropriate medical, dental, nursing, and pharmaceutical societies should appoint committees to ascertain the facts regarding the provision of medical service, to study the various possibilities for extending the service, and to prepare local or state plans accordingly. To provide a full and balanced view of problems and needs, to contribute administrative experience, and to give added weight to recommendations, such committees should include informed lay persons and should establish cooperative relations with official health agencies and with representatives of appropriate public organizations, such as community chests.

The community may properly look to its physicians, dentists, and other persons who have full-time interest in the problems of medical economics to furnish dynamic leadership in community planning. It is of paramount importance that the interest and knowledge of the professional groups be engaged, at an early stage, in constructive, practical efforts.

4B. Permanent Local Coordinating Agencies.*—In each community, permanent, local agencies should be established to evaluate and to coordinate the existing preventive and curative medical services, to eliminate services not needed, and to stimulate the provision of additional services which are needed. Such agencies should make a continuing study of the problems of organization and payment and should prepare a plan for progressive development. They should include representatives of the public, the medical professions, the health

* For a description of various coordinating activities see Chapter IV, p. 93, and Miscellaneous Contributions No. 12.

agencies, the hospitals, and the social agencies. They may well grow out of existing health and hospital councils or public health councils. Sufficient funds should be provided for executive and secretarial service. Funds or services may be provided by community chests, chambers of commerce, and local governmental or voluntary health agencies.

In cities, and perhaps in some rural areas, special committees or councils of the local coordinating board should be organized, on a permanent basis, to deal with various fields of medical activity. Hospital and nursing councils, having already demonstrated their value, should be among the first of such councils to be organized. Physicians, dentists, medical social workers, and pharmacists might desire special councils of the coordinating agency to deal with their particular problems. The programs of these various groups should harmonize with the broader program for the community.

4C. State Coordinating Agencies.—At the earliest possible date, there should be set up in each state a permanent, organized agency for the study of the problems of medical care. Such a body, like the local bodies discussed above, should include representation from the public, from the medical, dental, nursing, and pharmaceutical professions, from the public health services, the hospitals, and the voluntary social agencies. Like the local coordinating agency, it should make a continuing study of the problems of organization and payment, and should prepare a plan for progressive development. In addition, it should formulate such legislation as it considers necessary to further progress, to maintain professional standards, and to prevent the exploitation of either the professions or the public. Such a body may regionalize its activities by dividing the state into several medical districts, in order to give due consideration to geographic differences. It should give particular attention to medical service in rural areas and to the coordination of urban and rural facilities. Before organizing a state coordinating board, each state should consider whether some existing board or commission can be developed as a state coordinating board.

4D. Control of Drugs and Medicines.—State and Federal legislation should be enacted to prevent the sale of drugs and medicines with secret formulas. These laws should require

that the label on *all* medicines disclose the kind and quantity of all ingredients for which therapeutic properties are claimed and the disclosure of the same information in all literature accompanying the medicine or used in advertising it. Furthermore, all manufacturers of drugs and medicines should be permitted to operate only under licenses granted annually by the Federal government upon the fulfillment of prescribed conditions with respect to personnel, equipment, sanitary surroundings, and standardization of finished products.*

5. BASIC EDUCATIONAL IMPROVEMENTS

It is true in medicine, as in other fields, that the best is eventually the least expensive and that generally, therefore, cost is directly related to quality. But the best in medicine depends not only upon the type of economic organization which is provided, but even more basically upon the type of students who are attracted into the medical professions, the character of the education which they receive, and the opportunities which they have to continue their education after graduation. The physician is the basic factor in any plan for medical service. Some of the present difficulties of medicine, such as the oversupply of specialists and the poor services furnished by some general practitioners and by some specialists, with the consequent increase of costs to the patient, are caused by the character of medical education and by the fact that many physicians cannot or do not carry on postgraduate study. The Commission on Medical Education rightly regards qualified physicians as the first essential of satisfactory medical service. In the education of certain other medical practitioners far greater improvements are needed. Although the Committee, in its research, has made no direct study of professional education, it has unavoidably encountered educational problems.†

* *Additional Statement By Committee Members.*—We support the recommendation of the Committee and would add to it the recommendation that only qualified pharmacists should be allowed to sell drugs and medicines.—Lewallys F. Barker, Haven Emerson, Mrs. Walter McNab Miller, Alfred Owre, William J. Schieffelin, Winford H. Smith, Walter E. Steiner, John Sundwall.

† The reader who is interested in information about professional education is referred to the various reports of the Commission on Medical Education, to *Nursing and Nursing Education in the United States* (Macmillan Company, New York: 1923), to the reports of the Committee on the Grading of Nursing Schools, to the forthcoming report of the Curriculum Survey Committee of the American Association of Dental Schools, and to *Basic Material for a Pharmaceutical Curriculum* (McGraw-Hill Book Company, New York, 1927).

Recommendation 5.—The Committee makes the following recommendations in the field of professional education: (A) That the training of physicians give increasing emphasis to the teaching of health and the prevention of disease; that more effective efforts be made to provide trained health officers; that the social aspects of medical practice be given greater attention; that specialties be restricted to those specially qualified; and that postgraduate educational opportunities be increased; (B) that dental students be given a broader educational background; (C) that pharmaceutical education place more stress on the pharmacist's responsibilities and opportunities for public service; * (D) that nursing education be thoroughly remoulded to provide well-educated and well-qualified registered nurses; (E) that less thoroughly trained but competent nursing aides or attendants be provided; (F) that adequate training for nurse-midwives be provided; and (G) that opportunities be offered for the systematic training of hospital and clinic administrators.

This recommendation involves the continued development of certain programs which have been making considerable progress and receiving much attention in recent years. Specifically these are:

5A. Medical Education (Physicians).—The content and character of the education given to physicians should focus major attention on those aspects of medical knowledge and technique which in the future will occupy a major part of the time and attention of practitioners. This means, especially, greater emphasis on preventive medicine in all aspects of practice, better training in the health instruction of patients, and more attention to problems of mental and social adjustment. Medicine is changing so rapidly that opportunities for frequent periods of postgraduate training are essential.

(a) *Preventive Medicine in Private Practice.*—Future medical practice, the Committee believes, will be concerned increasingly with the prevention of disease and defectiveness as well as its alleviation and cure. Medical students, therefore, should

* *Comment By Committee Members.*—We believe that section C of Recommendation 5 should read as follows "That pharmaceutical education be coordinated as much as possible with the broader aspects of medical and dental education and that greater stress be laid upon the pharmacists' responsibilities and opportunities for service in promoting the public health."—Haven Emerson, Ambrose Hunsberger, Alfred Owre, William J. Schieffelin.

be thoroughly instructed in the conduct and use of periodic health examinations, in the basic principles of psychiatry, and in the prevention of specific diseases. Such emphasis should not be confined to special courses in public health or preventive medicine but should, as far as possible, permeate all courses. This involves reorientation of the entire curriculum.

(b) *Training of Health Officers.*—Provision must be made for the training of more health officials and other sanitarians employed by governmental health departments. It is true that there are schools thoroughly equipped for the purpose, but it is also true that they are not well-attended except by foreign students and those provided with scholarships. The development of public health work has been delayed by a lack of competent men, almost as much as by the lack of financial support or by political interference. Most health officers today, while starting with degrees of Doctor of Medicine, have received their special training as apprentices. An apprentice system is no more satisfactory in this field than it is in other fields.*

(c) *Social Medicine.*—Medicine is not an abstract body of knowledge to be used only in a laboratory. It is a living science and art applied to, for, and by human beings and subject to their idiosyncrasies. It is a social as well as a biological science, and it has economic, psychological, and sociological relationships. The effects on physical and mental health of mass unemployment, under-nutrition, and poor housing should form a part of medical instruction. The social background and interrelations of medicine should be as much a part of medical education as the physical, chemical, and bacteriological backgrounds. Indeed, this point of view should permeate the entire professional training.

(d) *Specialism.*—The practice of specialties should be limited to those persons whose training or experience gives them a skill in their field distinctly above that which ought to be possessed by all well-trained general practitioners. According to the Committee's studies the real needs of the people call for three to five times as many well-trained general practitioners as specialists,† and most schools, therefore

* Basic to this training is the need of assured opportunities to engage in a field of work with established salaries and stable employment. This means budgeting by the units of government for salaries and proper protection from partisan politics. (See Recommendation 2.)

† Publication No. 22.

should concentrate their energies on producing well-qualified general practitioners. Some schools, however, may rightly wish to concentrate on offering educational opportunities particularly for specialists.*

(e) *Postgraduate Education.*—Opportunities should be more widely available for high-grade postgraduate instruction for practicing physicians. The remarkable additions to medical knowledge and technique during the last 25 years should be available in systematic and comprehensive ways to the physicians who were graduated 10, 20, 30, and 40 years ago. Undoubtedly group practice will assist practitioners in broadening their knowledge, both because of more intimate contacts with a wider group of confrères and because of better opportunity to obtain leaves of absence for postgraduate study. Opportunities for such study need to be more widely provided. Several of our great cities could wisely put at the disposal of medical schools the clinical and laboratory facilities of the public and voluntary general and special hospitals for the graduate and specialist education of physicians.

5B. *Dental Education.*—The improvements suggested for the education of physicians apply with equal force to the education of dentists, although purely preventive activities are already, perhaps, more widely pursued by dentists than by physicians. On the other hand, dentistry has emerged as a true profession more recently than medicine, and important educational problems must be faced.† Dentistry increasingly is regarded as an important branch of health service rather than a mere mechanical service for the maintenance and restoration of dental functions and facial comeliness. Dental disorders are directly related, both as effect and as cause, to general health. Therefore, in addition to his training in the technical subjects directly related to practice, the dentist should have adequate training in certain aspects of physics and chemistry and in the method and content of the basic biological sciences, such as anatomy, physiology, bacteriology, and

* While adequate educational opportunities will assist in providing qualified specialists, the problem of preventing unqualified men from practicing as specialists will remain. This problem is discussed under Recommendation 1, p. 114.

† A survey of dental curricula is now being conducted by the American Association of Dental Schools under a grant from the Carnegie Corporation. This survey will probably be completed in 1935. Various universities, including Columbia, Rochester, and Yale, are working on experimental medico-dental programs.

pathology. The dentist needs this broad training not only to do his own work properly but also to give sound advice to patients and cooperate intelligently with physicians. The present trend toward a broader pre dental education should be strengthened through the addition of survey courses in the social sciences. Dental schools should provide appropriate short postgraduate courses in public health subjects.*

5C. Pharmaceutical Education.—Drugs and medicines and medical supplies are essential to an adequate medical service, both therapeutic and preventive. Most of them are dangerous if unwisely employed. The preparation, standardization, and distribution of drugs, medicines, and medical supplies should be limited, as far as possible, to pharmacists who are prepared by education and training to render this responsible service and to protect the public against abuse. Physicians and pharmacists should unite to provide the public, as economically as possible, with efficient remedies and to protect consumers from exploitation.† There are enough if not more than enough colleges of pharmacy teaching undergraduate courses but there are very few giving graduate work.

Pharmaceutical education should emphasize the pharmacist's responsibility for public health and safety. It should have a sound background, cultural and scientific. It should be more closely correlated with education in other public health professions in order to prepare pharmacists to cooperate fully with physicians, dentists, nurses, and public health agencies.

5D. Nursing Education.—An oversupply of personnel, much of which is not of a professional quality, has created serious economic problems for nurses. The Committee on the Grading of Nursing Schools has shown that the present unrestricted

* *Additional Statement By Committee Members.*—We believe the ends both of economy and of dental education would be better served by even more drastic changes. We think dental education should be a matter for only bona fide university dental schools, working in close cooperation with university medical schools. The ultimate result, we believe, should be the incorporation of dentistry as a department of medicine and surgery. The medical course could be modified, in time, to meet the particular demands of the oral specialist. He needs, however, as much scientific knowledge and clinical education as any other specialist. The oral field is as important as any other. A variety of technicians and assistants could be trained, in shorter courses, for most of the routine work now performed in dentistry.—Morris L. Cooke, Haven Emerson, William T. Foster, Mrs. Walter McNab Miller, Alfred Owra, William J. Schieffelin, C.-E. A. Winalow.

† *Additional Statement By Committee Member.*—I believe that the medical as well as the pharmaceutical curriculum should emphasize these important ends.—Ambrose Humberger.

development of hospital training schools is flooding the market with nurses. Although many persons who need nursing forego it because of the cost, the growth in the number of nurses threatens to outstrip the needs of the people as it long ago outstripped their effective demands. Even before the current depression, unemployment among this group was extensive; yet the supply of new graduates continues to be poured out as the result of a hospital policy which ignores the needs of the student and of the public in the interest of obtaining inexpensive hospital help. Moreover, the quality of instruction offered in many of these schools is too low to produce competent nurses, while the requirements for licensure in some states are so low that incompetent nurses are able to practice as though fully qualified.

There should be a rearrangement of curricula and a revision of the fundamental purposes of many nursing schools, so that they will produce socially-minded nurses with a preparation basic to all types of nursing service. The care of hospital patients is not, in and of itself, sufficient preparation for professional nursing. Nurses should be prepared not only for the practice of a profession but for life and its manifold home and community duties as well.*

Improvements in nursing education may increase the cost of care from graduate nurses, which even now often is a heavy financial strain on low-income families. This problem may be met in two ways: (a) by including nursing service among the benefits provided by industrial and university medical services, community medical centers, and other organized group payment plans,† and (b) by providing less thoroughly

* Some of the specific improvements needed in nursing education are: 1. Improvements in the basic education of registered nurses by (a) basic science instruction of collegiate grade, (b) diversified clinical experience in hospitals, (c) instruction in the principles of public health, (d) adequate funds and competent direction to insure good quality teaching, which can probably be provided by placing nursing education on a tuitional rather than a "worker" basis, and by obtaining public support on the same basis as it has been obtained for other types of professional education; 2. Provision of special instruction, both theoretical and practical, for public health nurses; 3. Provision of postgraduate training in clinical nursing, teaching, administration, and public health nursing.

† The Brattleboro plan of providing insured persons with graduate or attendant nurses at one-half or one-third the regular fees, rather than entirely without charge, appears to provide a peculiarly fortunate solution to the special difficulties inherent in offering nursing and housekeeper services on an insurance basis. If the entire cost of the service were provided from insurance funds, there probably would be many unnecessary calls. Under the Brattleboro plan, however, the limited insurance protection has cost only \$1.01 per person per year. See Publication No. 17, p. 80-81.

trained nursing attendants. These methods may be used simultaneously.

5E. Training of Nursing Attendants.—There is a need for trained nursing attendants who are competent to furnish simple nursing service under the supervision of visiting graduate nurses, who are willing to do housework when necessary, and who accept somewhat lower rates of pay. Attendants should work only under the auspices of agencies that can adequately supervise their activities. Their status, like that of all persons who nurse for pay, should be defined by law, and state registration or licensure should be compulsory. At the present time, however, there are large numbers of trained graduate nurses who are willing and eager to give either nursing or attendant service for fees as low as attendants' fees. The Committee recommends that the training of nursing attendants be provided but that such training should not be started until warranted by improved conditions of employment among graduate nurses and until adequate control by state licensure is obtained.

5F. Training of Nurse-Midwives.—The Committee believes that the time has come for the recognition of the part which may properly be played in the provision of medical care by the trained nurse-midwife. In many parts of the country, particularly the South, the trained nurse-midwife, working in conjunction with a skilled obstetrician, seems to offer the only solution to the difficult problems involved in providing proper maternity service to an economically weak and widely scattered population. The Committee therefore recommends that schools be developed for the training of nurse-midwives and provision be made for adequate state systems of registration and supervision of such practitioners. Preferably they should be directed by medical organizations or individuals who can provide competent supervision of their work.

5G. Training of Administrators.—Hospitals and clinics are not only medical institutions, they are also social and business enterprises, sometimes very large ones. It is important, therefore, that they be directed by administrators who are trained for their responsibilities and can understand and integrate the various professional, economic, and social factors involved. If the Committee's recommendations regarding community

medical centers and local and state coordinating boards are realized, there will be a demand for medical statesmen of a high order. Definite opportunities should be provided, either in universities or in institutes of hospital administration connected with universities, for the theoretical and practical training of such administrators. The administration of hospitals and medical centers should be developed as a career which will attract high-grade students.

All the recommendations presented by the Committee, it may be observed, are built upon existing institutions or agencies. The Committee does not propose the construction of new systems of medical service which parallel and duplicate those now in existence. Rather it suggests ways of incorporating existing personnel and agencies into new and more effective organizations. Great strides have been made during the last century in developing, improving, and extending medical services in the United States. Accepting what is in existence, each community faces the task of expanding and extending the usefulness of present facilities in such a way as to increase enormously the number of people who receive satisfactory medical care.

CHAPTER VI
THE CHALLENGE OF THE FUTURE

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During the last half century most of the great plagues which have devastated nations have disappeared from all civilized communities. The general death rate, with its accompaniment of suffering and crippling and economic waste, has been strikingly reduced—by nearly one-half in the large cities of this country. Such simple forms of magic as the filtration of water and the pasteurization of milk have exorcised the demons of cholera and typhoid fever. Malaria and hookworm disease are steadily giving ground, and the fear of diphtheria has been largely allayed. New knowledge of nutrition is yielding remarkable results in the treatment and prevention of many deficiency diseases.

Yet, as we survey the whole battle-field of the war between man and disease, we are struck by the fact that our victories have been attained only in certain sectors, while in others the enemy is holding his own or is even advancing. While reductions in the death rates from infant diseases, diphtheria, tuberculosis, typhoid fever, and other causes have resulted in an increase in the length of life, there remain many thousands of persons with uncorrected defects, a large proportion of illnesses that are uncared for, and a vast amount of preventable disease that is not prevented. Our failures result not only from insufficient scientific knowledge and from human weaknesses, but also from our failure to utilize existing knowledge, techniques, equipment, and personnel.

The successes of modern medicine have been achieved for the most part in those fields in which knowledge, techniques, equipment, and personnel have been organized under community leadership. Thus we have made concerted efforts to control infant mortality, tuberculosis, and the acute communicable diseases, and in large measure we have succeeded. Some disorders, on the other hand, have been left to the initiative of the private practitioner and the individual citizen with disappointing and sometimes negligible results. In our day it seems incredible that man studied the human body many thousands of years before he discovered what seems to

us so obvious a phenomenon as the circulation of blood, but future ages may be equally astonished over our failure to utilize existing knowledge and facilities for a determined attack upon disease.

There is abundant evidence that the people of the United States are ready to enlist in such a warfare. Newspapers and magazines are contributing a vast amount of subject matter on the promotion of health. Commercial enterprises are exploiting the interest of the people in the improvement of their health. Women's clubs and business men's organizations have assumed leadership in the attack on various disease problems. As one result of their work, thousands of crippled children have been provided with corrective treatment. More particularly, hundreds of universities and industries have taken the initiative in providing organized medical services for a small proportion of the people.

The outstanding need is for effective leadership. Wars are not won without it. In each local community, a representative body is needed to conduct a militant program over a period of years. This body in most instances may well be a local coordinating agency, such as the Committee has recommended. A few communities may prefer to increase the responsibility of health departments and accept their leadership. Each community must decide for itself what type of leadership promises to be most effective.

Whatever may be the nature of the group which the local community accepts for leadership, its effectiveness will depend largely upon an extensive knowledge and an unbiased attitude in regard to the existing situation. Obviously, there must be continued study of the diseases and conditions which are responsible for sickness and disability as well as a survey of all of the agencies, groups, and individuals which provide medical service. Private medical practice and public health work are so closely related that, in such a survey, it is folly to deal with them separately. If the community is to organize an effective attack on disease, all the facts must be systematically set forth in relation to all the other facts.*

* The survey may be conducted by a national organization, or by a local group representing not only the various agencies and persons engaged in providing medical care but also the consuming public. In either case, local agencies should participate in the survey.

With the necessary information available, the local community is ready for action. The agency which assumes leadership in the development of a program will consider carefully, it is hoped, the recommendations of the Committee on the

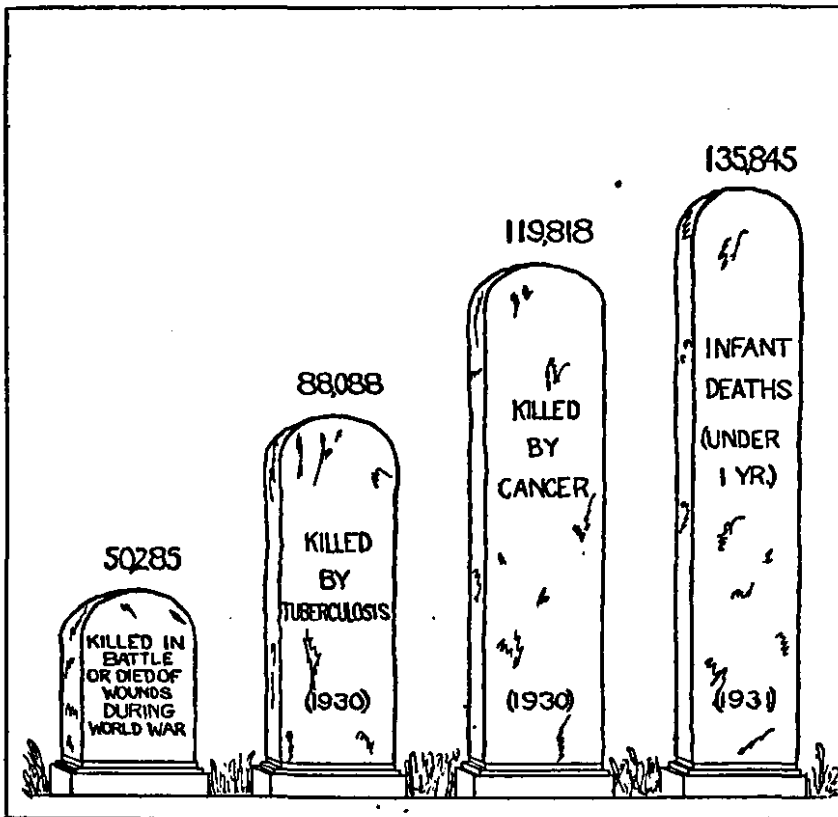


FIG. 18. "HUMAN LIFE IN THE UNITED STATES IS BEING WASTED AS RECKLESSLY, AS SURELY, IN TIMES OF PEACE AS IN TIMES OF WAR"

The graph shows the number of deaths in the United States, in years indicated, due to certain largely preventable causes, and the number of United States soldiers killed in battle or by wounds during the World War.

Costs of Medical Care. These recommendations are flexible and adaptable. But they do not exhaust the possibilities. The future is pregnant with opportunity. The local community must determine through careful study what kind of program is best adapted to its own particular needs.

In the various states, as in local communities, leadership may be assumed by a militant, state coordinating agency, by the state medical society, by the state department of health, or by some other agency. Here, also, the facts are essential as a basis for intelligent action. The state will not find a detailed program in the recommendations of the Committee, but must work out its own plan based on its own needs.

The cooperation of the professional groups in community or state leadership is essential. Their stake in these issues is very large; their interest is continuing. They should instigate as well as guide. The crucial point in the generalship of the forces at work is, perhaps, the development of a proper relation between the professional and the lay groups. The public should recognize the central place of the professional groups in determining standards and methods. The professions should recognize their ultimate responsibilities to the public. The control of undesirable commercial enterprises in this field will depend largely on the watchfulness of the professional bodies, on their ability to enlist lay cooperation, and on the development of sound and successfully operating non-commercial plans.

Continued study of the complex problems of medical economics is of the first importance. The Committee's investigations have opened a way. Fortunately, professional societies are establishing bureaus and committees on medical economics. Because a university has the unique advantage of having both medical and social scientists in one organization, the Committee has formally recommended to the universities of the country that they conduct research in this field.

Whatever means may be employed the time has come for action. European countries may not have proceeded with the greatest wisdom, but they have acted. Most of them have developed organized systems of medical care. We in the United States, above all other countries, are now in a position to go forward intelligently. With European experience available, and with the results of the five year program of study carried on by this Committee and collaborating agencies, a body of data is at hand which will enable each community and each state to take wise and adequate action.

Delay can no longer be tolerated. The death rates from cancer, diabetes, and appendicitis are rising threateningly. More babies are dying each year, many of them needlessly, than there were American soldiers killed in the World War. Every year tuberculosis kills its thousands and costs the country more than half a billion dollars. By early application of our knowledge we could double the cured cases of cancer. The venereal diseases still levy a heavy toll of blindness and mental disorders upon the nation. A great army of rheumatics remains untreated without hope of alleviation or cure. Many diabetics still remain without insulin or receive it too late. Human life in the United States is being wasted, as recklessly, as surely, in times of peace as in times of war. Thousands of people are sick and dying daily in this country because the knowledge and facilities that we have are inadequately applied. We must promptly put this knowledge and these facilities to work.

**MINORITY REPORTS
AND PERSONAL STATEMENTS**

RECOMMENDATIONS OF THE PRINCIPAL MINORITY GROUP

I

The minority recommends that government competition in the practice of medicine be discontinued and that its activities be restricted (a) to the care of the indigent and of those patients with diseases which can be cared for only in governmental institutions; (b) to the promotion of public health; (c) to the support of the medical departments of the Army and Navy, Coast and Geodetic Survey, and other government services which cannot because of their nature or location be served by the general medical profession; and (d) to the care of veterans suffering from *bona fide* service-connected disabilities and diseases, except in the case of tuberculosis and nervous and mental diseases.

II

The minority recommends that government care of the indigent be expanded with the ultimate object of relieving the medical profession of this burden.

III

The minority joins with the Committee in recommending that the study, evaluation, and coordination of medical service be considered important functions for every state and local community, that agencies be formed to exercise these functions, and that the coordination of rural with urban services receive special attention.

IV

The minority recommends that united attempts be made to restore the general practitioner to the central place in medical practice.

V

The minority recommends that the corporate practice of medicine, financed through intermediary agencies, be vigorously and persistently opposed as being economically wasteful, inimical to a continued and sustained high quality of medical care; or unfair exploitation of the medical profession.

VI

The minority recommends that methods be given careful trial which can rightly be fitted into our present institutions and agencies without interfering with the fundamentals of medical practice.

VII

The minority recommends the development by state or county medical societies of plans for medical care.

MINORITY REPORT NUMBER ONE

BY

A. C. CHRISTIE, M.D., GEORGE E. FOLLANSBEE, M.D.,
M. L. HARRIS, M.D., KIRBY S. HOWLETT, M.D.,
A. C. MORGAN, M.D., N. B. VAN ETTEN, M.D.,
A. M. SCHWITALLA, PH.D., OLIN WEST, M.D.,
AND ROBERT WILSON, M.D.

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The minority group of the Committee whose names are subscribed to this report are in accord with the majority in many of their conclusions and recommendations. We find ourselves, however, in conflict with what we conceive to be the general tone or trend of the report and in certain instances in sharp disagreement with the recommendations for future action. We have also certain constructive suggestions to make which have been omitted or the importance of which has not been sufficiently emphasized in the report of the majority. We regret the necessity for a minority report, but we are convinced that we would fail in our duty both to the public and to the medical profession if we did not point out as forcibly as possible what we conceive to be unwise recommendations or omissions in the majority report of this Committee.

We are in full and hearty accord with the majority in its recommendations for "The Strengthening of Public Health Services" and "Basic Educational Improvements," and we agree to some extent with the pronouncements of the Committee in respect to coordination of medical services. The first effect of "strengthening public health services" will be a considerable increase in the total cost of medical care, but we have the hope that eventually great savings will come from decrease in the incidence and duration of certain diseases.

Some of the recommendations for coordination of medical services and for basic improvements in medical education are immediately practicable and will undoubtedly result in reductions in the costs of medical care. They are in line with the general progress of medicine and are based on sound experience. Many educational improvements are under way through the initiative of the medical and dental professions and college authorities. Among them one of the most important is the increasing emphasis upon the necessity for more thorough training of the general practitioner in all of those fields which only he can adequately fill. In this connection we call attention

to the fact that neither scientific medicine nor the organized professions have been unprogressive. They have assumed initiative and have maintained leadership in the advancement of scientific knowledge and in improving the methods of its application to human welfare. In the opinion of the minority the general trend of the majority report makes it appear that the medical profession has been static and unprogressive. This implication we believe to be unjustified by the history of medical progress.

We are in sympathy with the recommendations of the majority which deal with the better training of specialists and their proper control. This is another matter in which the medical profession has taken the initiative. There are already several specialties which have organizations for the certification of specialists. Extensive plans are being perfected by some state medical societies and by the American Medical Association looking to establishment of control of specialism. It should be remembered that specialism has made great contributions to medical progress. Its abuses are capable of control by the professions without any revolutionary changes.

We repeat that this minority is heartily in accord with the majority recommendations with respect to public health and progress in medical education.

With regard to the majority Recommendations 1 and 3, dealing with "Organization of Medical Services" and "Group Payment for Medical Service," the convictions of this minority are so divergent from those of the majority that they must be discussed in detail.

I. ORGANIZATION OF MEDICAL SERVICES

The minority group recognizes the desirability of better correlation of the activities of the professions and it is in agreement with the majority upon some of the suggestions under the above heading. There is nothing, however, in the facts elicited by the Committee nor in the general experience of the medical professions to lead us to believe that "organization" can accomplish what is claimed for it in the majority report. On the contrary, it seems clear to us that many of the methods advocated will give rise to new and greater evils

in the attempt to cure existing ones. Our views are set forth below under each heading of the majority report.*

IA. Community Medical Centers.—The emphasis placed upon this plan which is called “the Committee’s most fundamental specific proposal” we believe to be far beyond any possibility of its ultimate value. It is admittedly an idealistic plan based almost solely upon theory. There is nothing in experience to show that it is a workable scheme or that it would not contain evils of its own which would be worse than those it is supposed to alleviate. Above all there is no evidence to prove that it would accomplish what ought to be the first object of this Committee, the lessening of the costs of medical care. The plan is suggestive of the great mergers in industry, the main medical center being in the nature of the parent holding company governing the activities of subsidiaries and branches. The idea that size and power are synonymous with excellence and efficiency has received some severe blows during the current economic depression, and opinions concerning it are undergoing revision.

The medical center plan is the adoption by medicine of the technique of big business, that is, mass production. It seems almost impossible for those who are not engaged in the practice of medicine to understand that the profession of medicine is a personal service and cannot adopt mass production methods without changing its character. It is always the individual patient who requires medical care, not diseases or economic classes or groups. The neglect of this principle in other fields

* *Additional Statement by Member of Minority Group.*—My major objection to the recommendations of the Majority is against group practice and not against group payment. I favor group payment in the compulsory, as opposed to the voluntary, form. But I oppose group practice. From Publication 27, we learn that 40,000,000 people of the United States live in rural areas and in towns of less than 2,500 population, where there are no hospitals around which to form group clinics and where there are not enough physicians, dentists, and other professional personnel out of which to form group clinics that could furnish complete medical care. Therefore I would recommend that in all such communities every family be urged to select a family physician to whom shall be submitted all health problems as well as illness problems; that we urge the cooperation of this family physician with available laboratories, specialists, etc., the free use of all such whenever needed and the close coordination of such service in rendering adequate and complete medical care. This would preserve the essential personal relationship between physician and patient and restore the private general practitioner to his rightful place as the *key-man* in any effective system of rendering medical service. I consider this kind of cooperation better and fairer to all parties than the organization of such personnel into partnership groups.—Kirby S. Howlett.

has brought serious evils that are now being corrected only with great difficulty. When mass operation revolutionized industry, social movements tended to follow the industrial pattern. Even education took on many of the factory forms. Educators, social workers, and penologists are now all emphasizing the value of individual case work. Yet in none of these fields are the problems so intensely personal and individual as in that of medical diagnosis and treatment. Nowhere is there greater need of complete liberty of action and close continuous knowledge of the person to be treated nor greater necessity for confidence than in the relation between patient and physician. Medicine has accepted the modern idea of cooperation but has rejected the competitive, mass-production idea of the factory system as being destructive of the social values developed by professional traditions.

Among the many objections to the medical center plan which must occur to anyone familiar with the requirements of medical practice are the following: (1) It would establish a medical hierarchy in every community to dictate who might practice medicine there. This is inherent in the plan since any new member of the center must be chosen either by the chief or by a small staff. (2) It would be impossible to prevent competition among the many such centers necessary for large cities; cost would inevitably be increased by the organization necessary to assign patients to the various centers. This would add to the evils of medical dictatorship those of a new bureau in the local government with its attendant cost. (3) Continuous personal relationship of physician and patient would be difficult if not impossible under such conditions.

We look upon this plan as far-fetched and visionary. It has no practical relationship to the question the Committee has set itself to solve. Placed as it is at the very beginning of the Committee's recommendations it must create a doubt of the Committee's grasp of the problem to which it has addressed itself. It seems to us an illustration of what is almost an obsession with many people, namely that "organization" can cure most, if not all, human ills.

1B. Industrial Medical Service.—It is our opinion that this question, which is of great importance, has not been adequately

nor fairly dealt with in the majority report. The publications of the Committee (Numbers 5, 18, and 20) which describe existing industrial medical services fail, in our opinion, to give a true picture of conditions as they exist throughout the country. For each of these favorable reports many instances could be cited of industrial medical services where the results have been exceedingly unfavorable. These are types of "contract practice" which have been a source of controversy for many years. The Judicial Council of the American Medical Association defines "contract practice" as follows:

"By the term 'contract practice' as applied to medicine, is meant the carrying out of an agreement between a physician or group of physicians, as principals or agents, and a corporation, organization or individual, to furnish partial or full medical services to a group or class of individuals for a definite sum or for a fixed rate per capita."

It should be remembered that the medical profession does not object to contract practice *per se* but only to the unethical practices which may attend that method of rendering medical services. There are numerous conditions under which it may be ethical for physicians to enter into contracts to furnish medical care. In isolated mining or lumbering camps medical service can be had only by entering into contract with some physician. Under workmen's compensation laws in some states employers and insurance companies are compelled to provide medical care in such a way that it can be secured only by some form of contract. This came about because workmen's compensation laws in most states were written without regard to the character of medical service under such laws. Defects in the laws are gradually being corrected to provide for a better quality of medical service. Another type of contract practice which cannot be considered unethical is that in isolated communities or sparsely settled rural districts where medical service can be secured only by contracting with a physician to pay part or all of his compensation.

Contracts must be considered unethical and injurious both to the public and to the physician when any of the following features prevail: (1) When there is solicitation of patients, either directly or indirectly. (2) When there is competition and underbidding to secure the contract. (3) When the com-

pensation is inadequate to secure good medical service. (4) When there is interference with reasonable competition in a community. (5) When free choice of physicians is prevented. (6) When the contract because of any of its provisions or practical results is contrary to sound public policy.

Contract practice has been in existence in the United States for many years and lately under the influence of poor economic conditions and the pressure of promoters is becoming widespread. Its chief features are summarized as follows by R. G. Leland: *

(1) Took its origin largely from necessity (isolated conditions); (2) has been legalized in certain places by state statute; (3) under certain conditions and in some forms is both ethical and legitimate; (4) in general, has become highly commercialized and competitive; (5) is largely limited to the pay-roll class; (6) does not, in most cases, extend its provisions to women and children; (7) confines itself, almost without exception, to curative medicine and does not include preventive measures; (8) shows no interest in public or individual welfare; (9) furnishes medical care which is often inferior in character; (10) in many instances is characterized by underbidding, subletting, misrepresentation and racketeering; (11) is economically unsound in many of its present forms; (12) is essentially sickness insurance, usually not supervised or regulated; (13) is often used by the operators thereof to influence legislation in favor of extension of the plan; (14) in many of its present forms, lowers the confidence of both individual and the public in the medical profession; (15) has some features that deserve refinement and extension and others that are unethical and dangerous and should be abolished.

So many abuses have always attended nearly every form of contract practice that the minority is willing to recommend it only when the objectionable features named above can be eliminated.

One of the strongest objections to industrial medical services, mutual benefit associations, so-called health and hospital associations, and other forms of contract practice is that there has been found no means of preventing destructive competition between individuals or groups concerned with these movements. This injects a type of commercialism into medical practice which is harmful to the public and the medical professions and results in inferior quality of medical service.

One of the pernicious effects of contract practice schemes is

* *Journal of the American Medical Association*, March 5, 1932, Vol. 98, pp. 808-15.

that each of them stimulates the launching of other similar schemes until there are many in the field competing with each other. The first may have safeguards against many of the abuses of contract practice, but as new ones are formed the barriers are gradually broken down in order to secure business.

There are general objections to all such methods of furnishing medical care which have been pointed out by representatives of organized labor. They are essentially paternalistic in their operation, giving to the management of industries an increased control over their employees. The intrusion of the company employed doctor into intimate family relationships is objectionable. Privacy and the personal relationship which should exist between patient and physician are broken down. The records of the patient's illness are in the files at the disposal of the company officials. Free choice of physician is absent; coercion is inevitable. Fear of loss of his job compels the employee's consent to the plan and to the doctor furnished by the company.

It is the belief of the minority group that the majority report has presented this entire question in a distorted manner. The evils of contract practice are widespread and pernicious. The studies published by the Committee show only the favorable aspects. They were selected because they were considered the most favorable examples of this type of practice in the United States. For each of these plans a score of the opposite kind can be found. The evils are inherent in the system although they may be minimized when a high grade personnel is found either among employees or medical group, or both.

Any method of furnishing medical care which degrades the medical profession through unfair competition or inadequate compensation, or which breaks down its ethical standards or furnishes inferior medical service, must be condemned. It is hardly open to doubt that contract practice, as usually carried on, is such a method.

Industrial medicine as it operates under workmen's compensation laws is further discussed below under "Group Practice."

1D. Utilization of Subsidiary Personnel.—This recommendation is nothing new in medical practice. It has already developed along many lines through the initiative of the medical, dental, and nursing professions. We need cite only the

widespread employment of technicians in clinical laboratories, the use of dental technicians and hygienists both for laboratory and clinical work, and the extension of nursing service. In radiological departments in hospitals, clinics, and private practice important duties have been assigned to technicians, and their services are being widely utilized. Even in those fields specifically mentioned by the majority report there have already occurred many advances in the directions recommended. We wish to add a word of caution relative to the dangers involved in permitting non-medical technicians to assume the duties which only physicians should undertake. There is constant temptation in many fields to permit technicians to perform duties entirely unjustified by their knowledge and training. Deterioration of service invariably results from such practice.

1E. Private Group Clinics.—We believe the establishment of such clinics is in line of progress when they are a natural outgrowth of local conditions. It is the belief of the minority group that the majority report gives far too much importance to the value of this type of medical practice. That it has accomplished generally or can ever accomplish what is there claimed for it is open to grave doubt. There is nothing in our own experience nor have we been able to find anything in the Committee's studies to lead us to conclude that group practice can furnish in general better or cheaper medical care than we have at present. In cities above 100,000 in population the multiplication of groups results in duplication of laboratories, expensive equipment, and overhead charges which make the system not less but more expensive than the present method. It usually results not in fewer specialists but more, because each group feels that it must have a representative of each important specialty. Even if it were possible to preserve the personal relationship of physician and patient in group practice, which is admittedly difficult, the method has only limited applicability. We wish to call attention to the fact that the studies published by the Committee on "Private Group Clinics" were far too few in number to constitute a safe base upon which to erect so large a structure as is proposed. This is especially true since no evidence is produced to indicate lower costs to patients. The studies of the Committee which show

40 per cent overhead in the practice of private physicians and 15 to 25 per cent for groups fail to tell the whole story. It must be remembered that groups usually offer only partial service and that when full domiciliary care is offered it is often provided through young and inexperienced doctors on a low salary. Costs can always be reduced through a restricted or inferior service. The most important discrepancy in conclusions drawn from the above studies arises from failure to consider the fact that multiplication of clinics or groups in large communities results in provision of expensive equipment far beyond the needs of the community. It serves no good purpose to reduce overhead in individual clinics if the total cost to the community is increased through duplication of plants.

The establishment of groups within recent years in many cities throughout the United States to treat patients under workmen's compensation laws or under contracts made with employers or groups of laymen has resulted in many abuses. Such groups are now in competition with each other, many of them openly soliciting patients through paid agents, many of them controlled by laymen and most of them constantly trying to keep down the cost of operation by employing physicians of inferior ability. Such groups, now scattered all over the United States, are rapidly resulting in the commercialization of medicine and the destruction of professional standards. Under such a system the tendency is to reduce medicine to the status of a competitive business instead of a profession with high ethical standards.

It is not our contention that all group practice has the above results but only that many groups have already been formed to practice under the commercial arrangements indicated. It is important in judging this question to give attention not only to those successful and favorable experiments in group practice cited in the majority report but also to take account of the scores of clinics which have failed and of the large numbers which are at present engaged in a type of practice inimical to every fine tradition of medicine.

Other Disadvantages to the Physician in Group Practice.— Except for the heads of the group, freedom of action is restricted in respect to vacations, study, travel, attendance upon scientific meetings, and even publication of medical articles, by

the will of the chief or chiefs of the clinic. It is contended by proponents of group practice that the physician can advance in professional knowledge more rapidly if he is assured of opportunities for study and is relieved of financial worries by the group, than is possible in private practice. It was pointed out above that only the chiefs of a clinic have freedom to advance along lines of their own choice. Subordinates are not permitted to pursue any course contrary to the general policies of the clinic. It is also very doubtful if men placed on a secure financial footing by a group contribute any more to progress than do those who are impelled to their best work under the stimulation of individual competition, scientific ambition, and initiative. The income of members of a group, except that of the owner or owners, while fairly stable, is comparatively static. When a salaried employee advances in salary to a point no longer profitable to the clinic, his income remains fixed. He then has the choice of waiting until someone ahead of him, whose place he can fill, dies, or of leaving the clinic and starting to build a practice at a time when he should be reaping the rewards of experience and ability.

The plans advocated in the majority report involving groups made up of general practitioners and specialists are theoretically attractive but thoroughly impractical. We are still far away from the time when the general practitioner will be accepted by a group of specialists as the correlator of their work.

We wish to make it clear that the above discussion of group practice does not refer to the association of physicians upon the staffs of hospitals nor their contact and consultation in clinics.

Groups of specialists as distinctive organizations are very valuable for diagnosing or treating difficult or complicated cases but for the 85 per cent of illnesses which make up the family doctor's practice better service can be given by the individual doctor in his own office than in a clinic, and at less cost.

It should be remembered that medical groups are subject to financial failure, just as are other business ventures. This has happened repeatedly and is not prevented by having a lay business manager in charge of finances. In periods of economic depression the group with its large overhead, first cuts salaries, then discharges employees, both professional and lay, and

finally may be forced to close. A frequent cause of failure and disruption of clinics or groups is the death or disability of some able man or men about whom the clinic has been built. When a group is forced to close, the physicians must seek employment in some other group or attempt private practice. The latter is usually very difficult because men in a group usually have little personal following and may have little training to practice general medicine. It should be remembered that patients who go to a clinic are the patients of the clinic and not of any individual doctor. Failure of a group may also have a very injurious effect upon the medical care of the community which is more or less dependent upon it. The private practice of medicine is likely to be a much more stable system, year in and year out, than any system based upon groups. When hard times come and the clinic must keep up its prices to meet its overhead, the private practitioner simply continues to care for his clientele and, with the rest of the community, takes his chances on receiving his pay.

The minority recognizes the advantage of group practice under certain conditions, especially in communities where practically all of the physicians can be joined in one, or at the most, in two groups. It does not believe that group practice offers any real solution to the problems of the cost of medical care except under very restricted conditions. The dangers of group practice are already apparent and the advantages either to the medical profession or to the public are limited.

IF. Pay Clinics.—We approve the development of pay clinics when they are under the management and control of physicians and are conducted on a high ethical plane and are needed to meet a situation. The same ethical considerations should prevail in the relations of clinic and patient as are operative between the private physician and his patient. There is no magic in the name "clinic" that can make it ethical for its agents to solicit patients in its name when it is considered unethical for a physician to do so as an individual. The traditions of the medical profession are strongly opposed to advertising and to solicitation of patients. If the ethics of the profession are broken down at this point, inroads will soon be made at other points, and the profession of medicine will degenerate into a competitive business without professional ideals.

When clinics are owned and controlled by laymen, the evils are accentuated. Clinics so owned or controlled result in the exploitation of the public and the medical professions and in an inferior quality of medical service or an increase in the costs of medical care, or both. When the middleman enters into the picture, the costs of medical care are always increased and quality is sacrificed. This is true whether the middleman is a layman or a corporation running a clinic, or an insurance company which must charge costs of operation to the patient.

IJ. County Medical Society Clinics.—The subject is dismissed in the majority report as of little or no importance. The minority believes that this is an important development which may be very valuable in solving the problems of medical care. We discuss it among other specific constructive suggestions offered later.

II. GROUP PAYMENT FOR MEDICAL SERVICE

The Committee on the Costs of Medical Care has been in existence for five years and during that time has collected at considerable expense a great body of data. Among these data are extensive comments on insurance medicine as it has developed and is now working out in various countries in Europe, and also in this country. In 1931 Simons and Sinai conducted a study of health insurance for the American Dental Association which the majority report of the Committee summarizes on page 99. One of the statements in their summary is as follows: "Every attempt to apply the principles of voluntary insurance on a large scale has proved to be only a longer or shorter bridge to a compulsory system. Every so-called 'voluntary' system is successful in just about the proportion that it contains compulsory features." Nothing has been made clearer than the fact that voluntary health insurance schemes have everywhere failed. In Europe they have been replaced by compulsory systems which are now under trial. Even in Denmark, where the system is nominally voluntary, there are indirect but very effective means of compulsion. In spite of these facts the majority of the Committee makes definite recom-

mendations that this country adopt the thoroughly discredited method of voluntary insurance. It is admitted in the majority report on page 125 that there are many dangers inherent in the plan. The principal safeguard against these dangers offered by the majority is to tie the voluntary insurance system up with the visionary medical center plan which they have earlier offered as the "keystone" of all medical service. We have tried to show that such a medical center simply substitutes new and greater evils for old.

It seems clear that recommendations for further trial and expansion of voluntary insurance schemes in the United States are entirely inconsistent with the Committee's own findings. To recommend that our own country again experiment with discredited methods of voluntary insurance is simply to ignore all that has been learned by costly experience in many other countries as well as in our own.

Voluntary insurance systems are now in operation in many parts of the United States and are increasing in number and in size. In many places these schemes are being operated in accordance with the plan recommended by the majority of the Committee, that is, by making contracts with organized groups of the medical profession. That they are giving rise to all the evils inherent in contract practice is well known. Wherever they are established there is solicitation of patients, destructive competition among professional groups, inferior medical service, loss of personal relationship of patient and physician, and demoralization of the professions. It is clear that all such schemes are contrary to sound public policy and that the shortest road to the commercialization of the practice of medicine is through the supposedly rosy path of insurance.

The careful reader of the majority report will note that not all of those who sign that report are willing to recommend voluntary insurance. Arguments against the voluntary system are forcibly set forth by the dissenters among the majority on page 131.

It seems clear, then, that if we must adopt in this country either of the methods tried out in Europe, the sensible and logical plan would be to adopt the method to which European countries have come through experience, that is, a compulsory plan under governmental control.

Before doing so, however, we should carefully examine this plan as it operates in Europe at present and face the objections to it. It should be remembered that compulsory systems of health insurance in European countries are still under trial. There is still no convincing proof that under these systems the costs of medical care have been reduced nor that the new evils to which they give rise are preferable to those which they are supposed to abate. The statement that most of the physicians in England prefer not to go back to the system under which they practiced before is not convincing because the system under which they practiced before was one of widespread voluntary insurance.

The objections to compulsory health insurance are almost as compelling to this minority group as are those to voluntary insurance. The operation of every form of insurance practice up to the present time has resulted in a vast amount of competitive effort on the part of practitioner groups, hospitals, and lay controlled organizations. Such competition tends to lower the standards of medical care, degrade the medical personnel, and make medical care a business rather than a profession. Proof of this is at hand in our own experience in this country with the only compulsory system with which we have yet had to deal, workmen's compensation insurance. The results named above are prevalent in many states. This is the rule to which there are a few notable exceptions. Under workmen's compensation, groups are soliciting contracts, often through paid lay promoters; laymen are organizing clinics and hiring doctors to do the work; standards of practice are being lowered; able physicians outside of the groups are being pushed to the wall; the patient is coerced by his employer to go to a certain clinic; and the physician is largely under the control of the insurance companies. These are not visionary fears of what may happen but a true picture of widespread evils attending insurance practice. We should need no better example of what must happen to medical care if compulsory insurance is extended to families.

There is one aspect of any system of insurance which should be kept in mind by all students of this question, namely, that the total cost of medical care is usually increased when it is paid for through insurance. There are two reasons for this.

First, the cost of operation of the insurance plan must be added to the cost of medical care. The majority report recognizes this by the following statement on page 50: "The participation of insurance companies in the forms of insurance against the costs of medical care which are recommended in this report would, the Committee believes, tend to increase the costs and not to improve the service." The majority report, therefore, approves of insurance but disapproves of insurance companies. This means, of course, that the majority report favors some form of insurance through a non-profit organization. The minority agrees that this principle should always govern in any plan of contract practice that may be necessary to meet the needs in a particular situation. The patient's fees will then be available for the costs of medical care, aside from the necessary costs of administration. The second reason for the increased cost of medical care under insurance systems arises from a fact which has been thoroughly demonstrated, that is, the number of persons sick and the number of days sickness per capita always increase under any system of insurance. This is shown to be true for European countries by Simons and Sinai and has been demonstrated in relatively small health insurance projects in this country. "Contrary to all predictions, the most startling fact about the vital statistics of insurance countries is the steady and fairly rapid rate of increase in the number of days the average person is sick annually and the continuously increasing duration of such sickness. Various studies in the United States seem to show that the average recorded sickness per individual is from seven to nine days per year. It is nearly twice that amount among the insured population of Great Britain and Germany, and has practically doubled in both countries since the installation of insurance." *

We are not here attempting to marshal all of the facts or arguments that can be used against health insurance. Innumerable articles have been written on the subject. No absolute judgment is possible at the present time with regard to what place, if any, insurance should finally have in helping people to pay for medical care. We have tried only to show here that there are great dangers and evils in insurance practice which

* *The Way of Health Insurance*. A. M. Simons and Nathan Sinai. Page 157.

must be set over against the advantages of distributing the costs of medical care by this method and which, it seems to us, the majority report has minimized. The dangers are especially directed at the continued well-being and progress of the medical professions, which, after all, are the ones most concerned in maintaining a high grade of medical service. It ought to be remembered that compulsory insurance will necessarily be subject to political control and that such control will inevitably destroy professional morale and ideals in medicine. Since a qualified and untrammelled medical profession is the only agency through which scientific medicine can be applied for the benefit of the people, it follows that any plan which destroys professional morale will bring disaster to the public. One of the conclusions of Simons and Sinai * is of especial significance in this connection. "While the statement might be disputed by insurance societies, a comparative study of many insurance systems seems to justify the conclusion that the evils of insurance decrease in proportion to the degree that responsibilities, with accompanying powers and duties, are intrusted to the medical professions." This statement is both a challenge to the medical profession and a warning to those who, without proper consideration of that profession, are willing to recommend the adoption of various new plans for the care of the sick.

It is our conviction that the Committee on the Costs of Medical Care would have served its stated purposes and the cause of medical progress and the people's health much better if it had taken a strong stand against all of those methods of caring for the sick which have in them the dangers and evils of "contract practice." By doing so they would have come to the assistance of the medical profession in a battle against forces which threaten to destroy its ideals, disrupt its organizations and completely commercialize its practice, and which are at the same time opposed to the public welfare. The medical profession is now in many parts of the country extending and perfecting plans through which it can offer to the people in a more systematic way the services of *all* the physicians of each community at prices which all the people can afford. It is only

* *Loc. cit.*, p. 206-207.

by including *all* of the members of the medical profession of a community that the abuses under insurance systems may be avoided. The nature of some of the plans is indicated under the minority recommendations below.*

III. RECOMMENDATIONS OF THE MINORITY

The minority group in offering the following recommendations has tried to keep in mind the main object which called this Committee together, namely to find some solution for the problem of furnishing good medical care to all the people at prices which they can afford. We have no delusions that our recommendations, even if fully put into effect, will solve all the problems of medical care. We have tried to approach the problem from a practical standpoint and to suggest progressive changes in the present system rather than to offer new methods based largely on theory and revolutionary in their practical application. We believe that our view-point is divergent from that of the majority in this respect. We are not opposed to progress nor to the adoption of new procedures. We are especially concerned, however, that new procedures be based upon sound experience and that in adopting them we do not lose the values that have been accumulated through the centuries. It is true in medicine as in all other fields of human experience that the soundest and most lasting progress is brought about slowly and step by step. Medical practice in the United States is progressing in this manner. We believe this to be the truly scientific method. We are loath to adopt revolutionary theories, however attractive they may seem, which may have within them the seeds of more harm than good.

It has been stated in the majority report of this Committee that we must plan twenty to fifty years in advance. We doubt our wisdom to do this. If society changes as rapidly in the next fifty years as in the past fifty, it seems presumptuous to assume that we can foresee conditions or needs sufficiently clearly to plan so far in advance. It is not too soon, however,

* *Dissoning Statement by Members of the Minority Group.*—We are not in entire agreement with the above condemnation of compulsory health insurance. We believe it may be possible to guard against many of the evils of the system, and that it is worthy of a trial.—Kirby S. Howlett, Robert Wilson.

to plan for the profession which is to furnish medical care a generation hence. If that profession is to attract young men of ability and high ideals, the great traditions of medicine must be preserved. We repeat here what we have stated earlier in this report that reductions in the cost of medical care which are obtained at the cost of degrading and demoralizing the professions upon which the people must depend for that care are far too costly to be of real value.

In making its recommendations the minority has had constantly in mind the first postulate set down at the beginning of Chapter II in the majority report to which we unreservedly subscribe. It is as follows: "The plan must safeguard the quality of medical service and preserve the essential personal relation between patient and physician."

The term "personal relationship" used so frequently throughout the Committee's publications and in the final report conveys but a vague meaning as to its essential elements and the reasons for its emphasis.

By personal relationship is meant that bond of sympathy and interest in the patient's welfare on the part of the physician, confidence in the ability, integrity and discretion of the physician on the part of the patient, and mutual regard on the part of each for the other which cause the patient to disclose for the purpose of diagnosis and treatment the most private and confidential information concerning himself and his surroundings when necessary for proper diagnosis and treatment. The character and personality of the physician is a major factor in its development and in process of time and continued contact as patient and physician a friendship and intimacy develop that assumes priestly characteristics on the part of the physician—the characteristics of the confidant and adviser in the most intimate personal and family relationships. All phases of personal and family life are at times closely related to the diagnosis and care of an individual's condition, and economic and financial conditions are often as important in diagnosis and care as physical or mental abnormalities. It is an individual relationship, the product of character and personality and cannot be transferred to a group or fostered by group practice.

It is our belief that the majority report in many of its recommendations for group practice and group purchase and in its emphasis upon what may be called "mass" practice instead of

individual practice has completely lost sight of this primary postulate.

Our recommendations are based upon the conviction that the medical profession is the essential element in the furnishing of medical care. Its influence should be upheld and strengthened and every assistance given to it to maintain its high professional standards. They are based upon the further conviction that the general practitioner is the most important factor in the medical profession and that he can function effectively only through the maintenance of private medical practice.

1. Government and Community Participation in Medical Care.—Many of the difficulties of the medical profession and a part of the problems of the costs of medical care to the moderate income groups would disappear if local and national governments and communities in general were properly fulfilling their obligations. On the one hand, there is failure to assume the full care of the indigent and, on the other, there is usurpation of the field which should be reserved entirely for private practice.

Recommendation 1.—The minority recommends that government competition in the practice of medicine be discontinued and that its activities be restricted (a) to the care of the indigent and of those patients with diseases which can be cared for only in governmental institutions; (b) to the promotion of public health; (c) to the support of the medical departments of the Army and Navy, Coast and Geodetic Survey, and other government services which cannot because of their nature or location be served by the general medical profession; and (d) to the care of veterans suffering from *bona fide* service-connected disabilities and diseases, except in the case of tuberculosis and nervous and mental diseases.

We stated early in this minority report that we heartily endorse the recommendations of the Committee which deal with strengthening of public health services. We emphasize especially the following points: (1) The need for more adequate training of medical students in public health matters; (2) the elimination of politics from public health administration; (3) improved standards in public health services to make them

more attractive to able men; tenure of position should be more secure and remuneration should be increased.

It is our belief that government should not extend its activities into those fields which can be effectively covered by the private practice of medicine.

We wish especially to emphasize our recommendations that the governmental care of veterans for general medical and surgical conditions be restricted to *bona fide* service-connected disabilities and diseases. The supply by the government of hospital facilities necessary to care for the more than four million veterans with their increasing disabilities as they advance in age will constitute a colossal waste. Last year from 25 to 40 per cent of the beds in civilian hospitals throughout the United States were empty. There is good evidence to show that all veterans can be taken care of in existing hospitals if non-service-connected disabilities are treated in civilian hospitals. The treatment of veterans by the government for non-service-connected disabilities has resulted in hardship to the medical profession by withdrawing many patients from private practice. The waste incident to the transportation of veterans back and forth between their homes and government hospitals is enormous. It is advantageous to the veteran to be treated near his own home by the physician of his own choice. This is especially important in acutely urgent diseases. We believe that the law providing for government treatment of non-service-connected disabilities should be repealed.

2. **Care of the Indigent Sick and Injured.**—It should be recognized that it is the duty of the state to give complete and adequate medical care to the indigent. One of the greatest burdens on the medical profession today is the care of the poor. Many communities provide hospital care for the indigent when they need it, although even this is not fully provided for in most communities. The full burden of the professional care of indigents not only in their homes but also in hospitals and clinics is thrown upon the medical profession. Attempts have been made to estimate the money value of the free service performed by the doctors of the country each year. It is practically impossible to arrive at anything definite by such attempts. It is known, however, that the medical profession has always performed this service without pay and few communities have

ever recognized any obligation to relieve them from it. It is obviously a burden which should be borne by the entire community and not by the medical profession alone. The doctor should bear his share like any other citizen through payment of taxes and support of the local community chest and other charitable agencies, but he should be paid by the community for his professional services to the indigent. The only exception to this should be where he renders service in an institution in which he receives his compensation in added prestige and experience. The community should also bear the total cost of hospitalization, nursing, etc., of every indigent person.

Recommendation 2.—The minority recommends that government care of the indigent be expanded with the ultimate object of relieving the medical profession of this burden.

If such a plan were made effective, its results would be far-reaching. The income of physicians would be increased. The young doctors would benefit especially because it is always in the first years of practice that a doctor treats the largest percentage of charity patients. Such a plan effectively carried out, would have a definite effect upon the cost of medical care to those who can pay for it. It would result in reduction of cost of hospitalization of pay patients because at present the patient must pay not only for his own care but in addition a certain proportion of the cost of the care of the indigent. It would be much more reasonable to determine whether or not communities can and will pay for the cost of medical care for their indigents, who are logically a charge against it, before plans are tried to compel the community to bear the costs of sickness of those who have incomes.*

3. Coordination and Control of Medical Services.—This is one of the recommendations of the majority with which we are in general accord. We wish to emphasize further the importance of putting these measures into effect in the immediate future. Much waste can be eliminated in our present system by the coordination of our present agencies and methods. The minority group recommends as a permanent coordinating body

* *Additional Statement by Member of the Minority Group.*—While accepting in general the principle of the state responsibility for the indigent, I cannot regard the responsibility as exclusive, since by such a policy the economic, social, and spiritual benefits to the public derived from private and voluntary philanthropy and charity would be endangered.—A. M. Schwitalla.

the agencies listed in the majority report. In order to initiate a progressive program for cities, counties, or states the appropriate medical, dental, and pharmaceutical societies and hospital associations should appoint committees to ascertain the facts regarding the provision of medical service; to study the various possibilities for extending the service; and to prepare local or state plans accordingly. We agree with the majority that "to provide a full and balanced view of problems and needs, to contribute administrative experience and to give added weight to recommendations such committees should include informed persons as associate members or should establish cooperative relations with representatives of appropriate public organizations such as community chests. . . . The community may properly look to its physicians, dentists, and other persons who have a full-time interest in the problems of medical economics to furnish dynamic leadership in community planning." We wish to emphasize the fact that medical and dental professions and hospital associations have already in many localities initiated movements intended to coordinate medical service. The success of these movements is likely to be in direct proportion to the degree of interest exhibited by the local professional organizations. They must increasingly assume responsibility for initiation and guidance of efforts in this direction.

These first three recommendations seem to us the first steps that should be taken in dealing with this problem. Their widespread adoption would eliminate so much waste from our present system that the problem would immediately take new and less urgent aspects.

4. Restoration of the General Practitioner to the Central Place in Medical Practice.—The next logical step after the three named above is further elimination of waste by increasing the efficiency and extending the field of the general practitioner of medicine.

Recommendation 4.—The minority recommends that united attempts be made to restore the general practitioner to the central place in medical practice.

This, of course, is quite the opposite of the majority's recommendations for concentrating medical practice in groups and medical centers. The majority report of the Committee recog-

nizes and emphasizes the extremely personal nature of medical practice. In the Summary Volume, Chapter XXIII, is found the following statement: "It (medical care) is also a personal service involving individual relationships between a medical practitioner and a patient. . . . The personal nature of disease and of medical care is the foundation upon which the economic organization of the past has been constructed, and must be the basis for expansion or reconstruction of the future. To ignore or deny the significance of this personal element in the economic organization of medical care would be as absurd as to overlook the laws of mechanics in the construction of a bridge." We have no doubt of the truth of the above statement nor of its fundamental importance. It contains the reason why we are opposed to all forms of medical practice which make it difficult or impossible to maintain the personal relationship of physician and patient. This is one reason for our insistence that the general practitioner must be kept in a central and important place in medical practice. Neither do we agree with the majority that savings in the cost of medical care are to be made by eliminating the general practitioner or submerging him in a group. Experience has taught us that the opposite is true. In a group the general practitioner tends to disappear. The great majority of illnesses and injuries (about 85 per cent) are of such nature that they can be treated efficiently by any able general practitioner with very simple equipment. In fact, the general practitioner does not need elaborate apparatus of any kind. His most important items of expense are his means of transportation and his rent. Neither of these can be greatly affected by combinations of general practitioners in groups. The organization of a group of 15 to 25 men results in increase in expense to the community, since the group must have complete apparatus for all branches of medicine whereas before they were joined in the group the entire 15 to 25 utilized the X-ray and other laboratories already established in the community. Theoretically there seems to be economy in group practice but practically this is true, as has already been pointed out, only in small communities where only one or two groups are necessary for the entire community.

Efforts, then, should be directed not to the elimination of the general practitioner but to the preparation of students in medi-

cal schools better to fill the important place that he has always occupied. The primary object of medical education should be to develop general practitioners. It is not that medical courses must become longer and more difficult but that the emphasis must be changed. The general practitioner is quite capable of taking over many of the procedures now assumed by specialists and should do so. It is not only in the field of diagnosis and therapy that the emphasis is changing, but it is now recognized that the general practitioner has a wide field in the prevention of disease. Instruction in this field should be improved in professional schools. In a word the general practitioner must be equipped to render good medical service to the families in which he becomes the trusted medical adviser.

Along with a change in the basic education of general practitioners, must go better training and better control of specialists. As has already been stated specialism has added much to medical progress. It needs now better control in order to fit it into our present life. Among specialists, group practice works to advantage and will eliminate some sources of waste.

5. Corporate Practice of Medicine.—A number of corporations have been formed in different parts of the United States for the purpose of selling the services of physicians to the public. Many of them include some type of insurance scheme. It is our belief that these schemes of laymen to exploit the medical profession and the public are a logical outcome of the many insurance schemes which have preceded them in this country and abroad. They are simply a further step in the commercialization of medicine. Their nature is clearly shown by the statement of one of them concerning the distribution of each dollar paid for medical care. Of each dollar, 45 cents is set aside for medical care not including hospital charges; 12.5 cents is for hospitalization; the remaining 42.5 cents goes to the company.

Some universities and some hospitals have capitalized the reputations and services of their professors in medicine or their staffs, charging fees commensurate with the ability of patients to pay for the professional services rendered by this essential personnel. The excess of fees collected above the salaries paid is a direct profit to the institutions and is derived from a personal service which the law permits to be rendered

only by an individual who is duly licensed to deliver and charge for such service. In some hospitals, the physician renders his services without salary or other emolument except the prestige of a staff position.

This minority group is opposed to all such schemes and offers the following recommendation:

Recommendation 5.—The minority recommends that the corporate practice of medicine, financed through intermediary agencies, be vigorously and persistently opposed as being economically wasteful, inimical to a continued and sustained high quality of medical care, or unfair exploitation of the medical profession.

6. Trial of New Methods.—Many experiments are being tried at various places throughout this country to assist the people in dealing with the economic aspects of sickness.

Recommendation 6.—The minority recommends that careful trial be given to methods which can rightly be fitted into our present institutions and agencies without interfering with the fundamentals of medical practice.

There are many plans developing at present which seem to us proper evolutionary developments and have the great advantage of being immediately practicable. They embody no revolutionary changes which might interfere with medical progress in the future. We note that the majority report minimizes the value of some such plans because they are only "palliative." We look upon this as an argument in their favor. Objection to so-called "palliatives," which with other like measures may relieve conditions so that no radical procedure is needed, would be similar to the surgeon refusing minor surgical or medical treatment on the ground that it might prevent a major operation.

Plan for Treatment of Chronic Diseases.—We call attention to a plan for treatment of chronic diseases which tends to improve quality of service, regulates the expense of treatment, and distributes the payments over a period of time. This plan is applicable under individual or group practice and has no objectionable features.

Under the system of charge per visit many chronic diseases do not receive adequate care. There are two major reasons: (1) indifference or ignorance on the part of the patient, and (2) economic reasons.

Indifference.—The development of chronic diseases is often so insidious as to result in a precarious condition of the patient before his trouble is brought to his attention. He is faithful in attendance and in following instructions until, in his own opinion, his trouble is cured or sufficiently relieved to need no further attention, and he postpones or stops coming for periodical check-up, either because he feels it not needed or because he objects to paying for visits which only assure him he is getting along properly or needs but minor changes in his routine. He therefore ceases to be under observation and control and soon returns to his former precarious condition. The treatment must then be carried out all over again, with its loss of time, increased expense, and advancement of the pathological condition. Often the patient does not return to the former physician and the necessary process of diagnosis and inventory must be repeated at additional cost and loss of opportunity to the patient. With continuous complete service for chronic diseases paid for on a yearly basis the temptation to relax in care would be largely removed.

Economic Reasons.—Only a small portion of the service necessary in the care of chronic diseases can be paid for by the majority of the people under the fee-per-visit system of charging, and one of the following conditions results: (a) The patient discontinues his treatment because he cannot pay and does not wish charity; (b) the patient continues to receive treatment and runs a bill which he can probably never pay; (c) the physician takes care of him as a charity patient after he has been charged the amount he can afford; (d) the patient is sent to a dispensary after he can no longer pay his doctor. This situation is bad for both patient and doctor, since the former needs continuous care by the same doctor and the latter desires to study and treat the entire course of a disease and not an isolated incident in it.

A satisfactory solution of this problem is found in the application of the following philosophy of practice. The doctor has knowledge and skill for sale. If he desires to treat patients with certain diseases, he must familiarize himself with the vagaries of these diseases and must possess the necessary equipment and skill in its use to perform all the necessary service. If the essential knowledge and skill is beyond the capacity of one individual then the one desiring to give the

major part of the service must ally himself with others giving the needed supplementary services, and must pay them for this service, charging the amounts so paid to his office expenses.

No patient should be charged separately for a visit or any particular part of the service, but for all of it, no matter what it comprises. Since chronic diseases need continuous supervision of the patient by the doctor the application of this principle requires that chronic diseases be treated for an inclusive fee to cover complete medical service for that disease for a definite period of time. This fee should be assessed on a sliding scale in accordance with the patient's financial circumstances, with a minimum just above the charity level and a maximum comparable to the fees now paid by the wealthy. This fee should bear no relation to the number of visits or the type of service rendered. Practice under this plan has been carried on since 1929 in The Asthma and Hay Fever Clinic in Cleveland with satisfaction both to doctors and patients.*

Payment under this plan can be made in advance or on a series of deferred payments as agreed to by the patient and physician. The former knows what his year's care will cost and need not worry over the number of visits or "extra" services. The latter has agreed to and knows just what he is to receive and when he will receive it. Relations between patient and physician are not subjected to any strain or reserve on economic grounds under this plan.

Another plan that is being tried extensively is the grouping of physicians' offices in or around a hospital. We agree with the statement in the Summary Volume in Chapter XXIV that "the centering of medical service in the hospital, which already represents an important concentration of capital investment and professional personnel, would appear to have practical advantages for physicians, hospitals, and patients." It is opposed to the principles we have laid down, however, for the hospital to control medical practice or to enter into the practice of medicine in any of its branches as an institution.

A caution that is necessary at this point concerns the danger of over hospitalization when all the medical activities are centered around a hospital. A further caution is necessary

* *The Bulletin of the American Medical Association*, June, 1931.

with regard to establishment of hospitals in localities where there is insufficient or unqualified personnel and where a hospital is not actually needed. The merit of a hospital depends upon the ability of the professional personnel who are charged with its work. It is not brick and mortar but men who make the value of an institution.

7. Development by State or County Medical Societies of Plans for Medical Care.—The recommendations we have offered up to this point are concerned with the elimination of waste, the abatement or avoidance of evident evils in present practice, and improvement in the quality of medical care. We have already set forth our objections to the majority's recommendations for adoption of insurance systems. We tried to make it plain that we are not opposed to insurance but only to the abuses and evils that have practically always accompanied insurance medicine.

Medical societies in various parts of the United States have been giving careful study to the question of the possibility of distributing the costs of medical care and at the same time avoiding the evils of insurance systems.

This minority group agrees that any plan for the distribution of medical costs must have the following safeguards:

1. It must be under the control of the medical profession. (A "Grievance Board" to settle disputes, having lay representation, is permissible and desirable).

2. It must guarantee not only nominal but actual free choice of physician.

3. It must include all, or a large majority of the members of the county medical society.

4. The funds must be administered on a non-profit basis.

5. It should provide for direct payment by the patient of a certain minimum amount, the common fund providing only that portion beyond the patient's means.

6. It should make adequate provision for community care of the indigent.

7. It must be entirely separate from any plan providing for cash benefits.

8. It must not require certification of disability by the physician treating the disease or injury.

This group recognizes the value of trial of plans based upon

the above principles by county medical societies. We believe that the county society, approved by and under the supervision of the state and national societies, is the proper unit of organization to attempt such experiments. Report will be found in the committee's findings of various county societies in Iowa which have been experimenting with caring for the indigent as a county society project. Our reasons for favoring thorough trial of the county society plan for furnishing complete medical care are as follows:

1. It places responsibility for the medical care of the entire community upon the organized physicians of the community.

2. It places medical care under the control of the organized profession instead of in the hands of lay-corporations, insurance companies, etc.

3. It places responsibility for the quality of service directly upon the organized profession. It is in fact the only plan which guarantees quality of service and makes it the only basis of competition.

4. It removes the possibility of unethical competition because it includes all the physicians of the community and fixes a fee schedule.

5. Solicitation of patients, underbidding for contracts and other evils of the usual insurance plans are eliminated.

6. Freedom of choice of physician is assured and the essential personal relationship of physician and patient is thereby preserved.

7. It is the only plan which includes all classes, from the indigent to the wealthy.

8. It is adaptable to every locality, both urban and rural.

9. It provides for a minimum cost of administration by operating on a non-profit basis.

10. It provides for payment, by every patient with income, of a certain minimum amount before the insurance is in operation. The minimum rises with the patient's income. This provision alone will operate to avoid many abuses in all other types of insurance practice.

11. It provides for means of certification of disability separate from the attending physician.

12. Cash benefits do not form a part of the plan.

The main objections urged against the plan are that it places too much power in the hands of the organized medical

profession, and that county medical organizations will be too lethargic to put the plan into operation.

It is the opinion of this group that it is much better to lodge power in the hands of the professions which are trained to furnish medical care than in the hands of lay corporations. This is especially true when, under the proposed plan, responsibility can be definitely placed on the organized professions for the quality of care furnished. The plan provides for settlement of individual disagreements or complaints by a "Grievance Board" with adequate lay representation. The objection to the plan on the grounds of lethargy of medical societies should not have great weight. Many medical societies are very active in promoting means for better care of the people of their communities. It is our belief that when the proposed plan has been in successful operation for a short time its advance will be spontaneous and widespread.

It is true that the plan in some essential respects is new, but it is based upon past experience. It is an attempt to distribute the costs of medical care by utilizing the good in insurance plans and avoiding their dangers and evils.

IV. CONCLUSION

The problem of the payment of the various expenses that accompany disease and injury has arisen as a result of developments in the medical field, on the one hand, and of complex changes in the economic and social order, on the other.

Within the past fifty years, as the Chairman of the Committee has emphasized in his introduction, revolutionary changes have taken place in the practice of medicine because of various important discoveries in the causation, treatment, and prevention of disease. Within that time bacteriology, serology, and the x-ray have developed; hospitals have grown to enormous proportions; nursing has come to occupy a place not formerly thought necessary; specialization is now an important part of medical practice; medical education occupies a far longer time and is much more expensive than formerly; and apparatus for the diagnosis and treatment of disease now requires the investment of a large amount of capital.

Such changes in themselves would have increased the costs of medical care, but the problem has been rendered much more complex by the rapidly changing conditions in society and industry. The population of the United States has changed in a comparatively short time from one predominantly rural to one in which fifty per cent of the people live in cities. This means that a much greater percentage of the people is now employed in industries than was formerly the case. Along with this urbanization and industrialization, there have developed radical changes in the standards of living. The luxuries of the late nineties are now necessities of life for great masses of the population. All of these changes, both in the practice of medicine and in society, have operated to cause an increase in the costs of taking care of people when they are sick. There is little doubt that the changes are desirable but it is obvious that they increase the costs of medical care.

It is plain, therefore, that many of the problems which are under discussion are the general problems of a transitional stage in social development and are not peculiar to medicine or medical care. Their solution must depend upon far-reaching social and economic adjustments. They are analogous to the problems which caused great social and political unrest in the last decade of the last century and which were not settled until there was a general increase in wages to compensate for improvements in the standards of living.

It does not seem probable to this minority group that these complex problems can be solved or necessary social readjustments hastened by the widespread adoption of the recommendations of the majority of this Committee for the group practice of medicine or group purchase of medical care.

Our understanding of the majority report is that it offers essentially the following type of medical practice in the future: The medical profession is to be formed into large or small groups, preferably large, and these groups are to furnish medical care under some type of contract with groups of laymen, the funds to be furnished by insurance, preferably of the voluntary type. Over against this we offer medical care furnished by the individual physician with the general practitioner in a central place; with groups and clinics organized only where the nature of the situation and character of the per-

sonnel render such organization a natural development; with elimination of waste in our present methods and coordination of all existing agencies; with careful trial of new methods based upon sound experience; and with adoption of insurance methods only when they can be kept under professional control and destructive competition eliminated; all of this through a well organized, untrammelled medical profession true to the great traditions and ethical standards of the past. Centuries of progress in the conquest of disease gives us confidence that the individual and not the group should remain the unit in the practice of medicine.

We wish to emphasize once more in closing our accord with the majority of the Committee in their recommendations for improvements in public health service and in the scope of medical education. We would especially express our appreciation of the great value of the mass of factual data compiled by the staff and so ably summarized in the Summary Volume.

A. C. CHRISTIE,
GEORGE E. FOLLANSBEE,
M. L. HARRIS,
KIRBY S. HOWLETT,
A. C. MORGAN,
A. M. SCHWITALLA,
N. B. VAN ETTEN,
OLIN WEST,
ROBERT WILSON.

MINORITY REPORT NUMBER TWO

BY

HERBERT E. PHILLIPS, D.D.S., AND C. E. RUDOLPH, D.D.S.

The undersigned are in accord with the main position of the majority of the Committee, in that we recognize existing professional and social trends in medical care as brought out by the Committee's studies and believe that these trends necessitate substantial changes in the manner in which medical service is rendered and paid for. There is no doubt in our minds that an increased amount of medical service should and will be rendered through professional organizations rather than by individual practitioners working independently. We also believe that payment for medical service by distributing the costs over groups rather than having it fall upon individuals is a sound principle when applied in such ways as maintain professional standards of service. We are in accord, therefore, with the general recommendations of the majority in favor of group practice and group payment, although we must register dissent from certain specific proposals and certain implications of the majority report which we do not consider justified.

We are, however, in accord with those who signed Minority Report No. 1 in strongly emphasizing the necessity of maintaining professional standards and the position of the general practitioner, and we recognize, as they do, that grave dangers to these standards have developed in the past and will exist particularly during a period of rapid changes in medical service such as we are undoubtedly facing. In our opinion, the most important influence for the maintenance of professional standards is vigorous initiative on the part of the professions themselves. They should, as individuals, and through their professional organizations, recognize frankly the existence of the problems and needs which are brought out by the studies of this Committee and should themselves take steps to deal with them, through initiating or participating in experiments in group practice and group payment. We realize that needs are more acute in some localities than in others and therefore early recognition of these needs should be made. Nothing, in our opinion, would be more detrimental not only to the medi-

cal service of the public, but to the welfare of the professions, than an attitude of opposition or mere aloofness on the part of the professions. We recognize that certain evils that have developed in group practice and in sickness insurance in the past have been chiefly due to lack of professional initiative and control and that with the assumption of initiative and control by the professions at this time these evils will be minimized in the future.

We feel with those signing Minority Report No. 1 that the attitude of the majority is unduly critical of the professions, and that this attitude has developed a bias in some of the statements in their report. We agree also that the investigation of industrial schemes by the Committee almost entirely overlooked their defects, and only the least objectionable and most successful were chosen for study.

We agree with Minority Report No. 1 that the description of the community medical center, which is set forth in the third chapter of the Majority Report as the ultimate goal of development, is Utopian in concept, and involves many details which are too visionary or problematical to justify inclusion in an authoritative report of this kind.

It is to be regretted that the Committee's studies did not include any study of dental group practice. Studies of such groups should have been made both as regards their organization and the quality of their service. The dental profession should initiate experimentation in dental group practice and should encourage cooperative experiments involving physicians and hospital service. Studies of the American Dental Association show that such cooperative participation is on the increase. All such experiments would provide valuable facts as a basis for future development.

We do not consider that voluntary and compulsory sickness insurance should be regarded as in opposition to each other or as unrelated proposals, as seems to be implied in the Majority Report. European experience indicates that methods developed under voluntary insurance have indicated the pattern for compulsory insurance later, and should furnish necessary experience for the United States. Experience thus gained in voluntary insurance, both by the public and the professions, would be an asset if and when certain states contemplate com-

pulsory systems. In certain sections of the United States, voluntary insurance has already developed to a considerable degree. It is true that in these sections certain evils have developed but it is probable that the introduction of compulsory insurance under professional control will eliminate the objectionable features. The more the difficulties are eliminated or controlled in the voluntary plan, the less risk of having objectionable features in the subsequent compulsory insurance.

We do not feel that this method of payment need interfere with the highest professional standards nor with the close personal relationship between practitioner and patient.

The studies of the Committee indicate that a large proportion of the population receive incomes, even during prosperous times, so low as to preclude the purchase, under any form of payment, of adequate medical service. This is emphasized by the following quotation from Summary Volume, Chapter XXXIV:

The significance of the economic barrier between the true need and the current receipt of medical care is especially evidenced by the finding that far greater inadequacies obtain for those of small than those of large means. Just as some people go hungry though the country produces more food than the people can consume; many are inadequately clothed though we manufacture more clothing than we can use; even so millions are sick, hundreds of thousands suffer pain and anguish, and tens of thousands die prematurely for lack of medical care which available personnel and facilities could supply. The tragedy concealed in this conclusion is the more poignant because medical practitioners and institutions are used to only part of their capacity—not because their services are not needed, nor because they are unwilling to serve.

We add to these reasons because fundamentally, as the studies of the committee reveal, the problem of providing medical care is a question of low incomes and the solution depends at least as much upon increasing incomes to a satisfactory standard of living, as upon methods of organizing medical care. We recognize, however, that the ability to purchase medical care on an insurance basis is greater than when the cost falls upon the individual family.

We are in accord with and strongly recommend medical society plans of sickness insurance such as those referred to in Minority Report No. 1, page 179. These would place responsibility on the professions for the maintenance of standards of service and would set up, for a state or a community, agreed

rates of payment so that competition between different professional groups furnishing service or between individual practitioners would be on a basis of quality of care and not on a basis of charges. It is destructive to standards of medical care, in which both the public and the professions have a common interest, if competition exists in such form as to bring about price-cutting and under-bidding for service. We strongly endorse the initiative of such professional bodies as the Milwaukee Medical Society * or the State Medical Society of California in endeavoring to meet their obligations to the public by developing plans of group payment. Such a form of organization of medical service under professional control will set a pattern which will determine the direction of any future development of organized medical care in voluntary or compulsory insurance. Such an opportunity typifies the attitude of the British Medical Association referred to in the quotation on page 118 of the majority report as follows:

Such a scheme may be compared to a plan submitted by an architect to a householder who wants to extend the house in which he lives, and to introduce all modern improvements. The householder may, on seeing the plan, decide that it would cost too much and that he must put up with his house as it is; or he may make suggestions for the modification of the plan. But the householder knows that if he wants to extend his house he is, as regards essentials, in the hands of the architects and builders.

We fully agree with the statement concerning coordination of medical service contained in Minority Report No. 1, page 172, as quoted from the Committee's report, page 134.

With a full knowledge of the inherent evils of the early competitive systems of medical and dental education, we believe it would be of great value if a national organization were to be formed to study group practice and to define its standards, and suggest that such a plan be sponsored by those bodies that have supported studies of medical and dental education.

During rapid social changes group practice and individual practice are developing side by side, and should develop in cooperation. Conflicts between those dealing in medical care under any auspices will have a disturbing effect on practitioners and a detrimental effect on the public, whom they

* See p. 75 of the Committee's report for a description of the Milwaukee plan.

serve. All of this is against professional traditions of medical care. These methods must meet in service, adjustment must be made so that conflicts may be eliminated, and codes must be adapted to meet changing conditions.

HERBERT E. PHILLIPS,
C. E. RUDOLPH.

STATEMENT

BY

WALTON H. HAMILTON

It is impossible for me to express my attitude towards the Report of the Committee by so categorical a word as "Yes" or "No." The document contains far too much which is constructive and forward-looking for me to be willing to dissent; yet its statement falls so short of an adequate attack upon the problem of medical care that I cannot persuade myself to concur. A substitute report, even if it were expedient to develop one's opinions at length, could not be prepared in the brief time available between the release of the final draft to the Committee and the hour at which all copy must be in. I must, therefore, confine myself to a short supplementary statement.

It is easy, but not very useful, to quarrel with the detailed statements in the Report. The document represents what all who have signed are willing to accept rather than what any individual would have written. Such minor flaws, however numerous, are inseparable from any collective statement of opinion. It is, however, unfortunate that the spirit of tolerance, admirable as it is, should have been so largely indulged. Its manifestation in the treatment of major matters and minor details on the same level, the resort to general but indefinite principles, the setting down of propositions in which the nouns give and the adjectives take away, are far too numerous. If the Committee were a formal agency, charged with the formulation of a constructive program, compromise would be justified as essential to action. But the task of the Committee is to study, to analyze, to investigate, and to report; it has no power to institute a single desirable reform; its labors can be converted into a better organization for medicine only through its influence upon groups who have authority to act. This end, it seems to me, would have been far better served, by cleancut—and even uncompromising—presentation of alternative programs. The sacrifice in analysis and precision to unanimity among the members of the majority may well give a greater influence to the recommendations. But the gain is only immediate, and the problem is likely to be with us for years to

come. In the end, the views of the Committee must prevail—so far as they do prevail—not because of the number of names attached, but because they commend themselves to the persons who may come to have the power to act. The gain in immediate appeal is bought too dearly when its price is the sacrifice of more durable values. It is fortunate that the challenge, voiced in the statement of the minority, gives to the Report a perspective which the document itself lacks.

It is, in fact, in matters of perspective and analysis that the Report exhibits its most serious shortcomings. As in a "close-up," it is the essential which is likely to be overlooked; so here it is the all-but-obvious which is barely discernible in the blurred lines of the picture. The concern of this investigation is the performance of a great social function, that of keeping the people in health; this is the beginning and the end of the problem of medical organization; all else that is considered here—physicians, nurses, hospitals, clinics, the drug trade, and the like—are agencies whose value comes from the efficiency and adequacy with which they contribute to that end. There is nothing final in any of these agencies; none of them in its current form is to be taken for granted in the discussion; the professional services which medicine has to offer may be made available to the public under any one of a number of distinctive sets of arrangements. A sharp distinction between the technology of medicine and its organization is essential to adequate analysis. The failure of the Report to make that distinction, and its repeated oversight of the instrumental character of the agencies which we employ towards health, obscure the lines of the argument.

In like manner, the analysis is limited by a failure to place the problem in its setting. The organization of medicine is not a thing apart which can be subjected to study in isolation. It is an aspect of a culture whose arrangements are inseparable from the general organization of society. The roots of many of the shortcomings of which the Report complains lie beyond its frontier; the ways and means for putting medicine in order must take account of the conditions of life and work among the people whom it must serve. Nor is the organization of medicine a thing which is; it was only yesterday a very different affair; and, whether we assert control or leave it to drift, it will be something different tomorrow. Its reality can, no more

than any other institution, be discovered in cross-section; its ills, no more than any other institution, can be successfully diagnosed by a static analysis. It is only as we see how it has come to be that we can appreciate what it is; it is only as we can direct its growth that we can control its future. The Report too generally ignores these actualities of social setting and development.

A single illustration must suffice to show how a genetic approach serves the end of analysis. The report refers to the large amount of "free service" given to the indigent as if it were an isolated phenomenon. The practice goes back to the time when the doctor, regarding himself as the servant of the community, gave his services to all in accordance with their needs, and collected fees from each of his patients in accordance with his ability to pay. Thus "charity work" and "the sliding scale" came into existence together; they are complementary aspects of the single institution of the collective provision of the physician's income; if the one imposed upon him an obligation, the other extended to him its correlative right. Each has, by the course of events, been diverted from its original purpose. It may well be true that today "charity work" imposes upon many physicians an unreasonable amount of work for which they are not directly paid; but it is equally true that physicians share with other men the capacity to rationalize their own interests, and that in our modern world the sliding-scale is an instrument easily capable of abuse. Above all, it is significant that the connection between the two has been broken, and that the older justifications are no longer relevant. The current problem lies neither in the excessive amount of free work—which for aught we know might well be larger—nor in an exorbitant rate of charges—which in certain income groups might well be much higher. It lies rather in our failure to contrive as a substitute for the professional principle of earlier days, a scheme for paying the physician which is in accord with the modern conditions under which he has to work. As with so-called free-service, so with other problems with which the Report is concerned; an historical account, in the service of analysis, will yield meaning and significance not to be found in a static picture.

And, as it is with the instance, so it is with the whole. An account of how it came into existence will throw the prevail-

ing organization of medicine into clear-cut relief. There can be no personal responsibility for the many unlikeable features of medicine revealed in the Report. No individual, no group, professional or lay, is primarily to blame; for the system—or lack of system—which we know was never designed nor even intended. The elements which make it up were not cut to blueprints nor brought together into a prearranged pattern. Instead, like any other institution—government, church, business, or what not—they grew up quite adventitiously in response to the most immediate and the most diverse necessities. And again, like any other institution, the many parts which hail from many separate ages have come to be crudely fitted together with a sprawling organization. An ancient and honorable craft had become a profession; the profession has lived on into an epoch in which it has had to make its terms with, to employ pecuniary devices from, and to respond to the incentives of, business. And state enterprise, whether or not we approve, has already marked out for itself areas in the ancient domain. In fact, almost every type of control known to society is to be found somewhere within “the medical order.” Along each of the seams of this conglomerate pattern a current problem is to be found. Structure has been defined as arrested function; and the problem of problems—which it is the essential task of this Committee to bring into the light—is the adjustment of this far-too-rigid and none-too-responsive organization to the social function which medicine must today be made to perform.

Although each of the services—professional practice, nursing, hospitals, whatnot—presents to some extent a distinctive problem, they are alike in exhibiting in greater or lesser degree disorder in structure and diversion from function. It would be interesting to pass them all in critical review; but a single case will have to do at least approximate duty for the whole. An epitome of the order and disorder which is medicine is to be observed in the plight into which private practice has been driven by the course of unintended events. In this country, up until near the turn of the century, the professional outlook and professional values were dominant. The “family doctor” was an institution; his trade was to him a sacred calling; his ideal imposed upon him the duty to serve all and commanded charity in judging human frailty. The patient at-

tached himself to the physician; his loyalty was of a kind with that given to church or party; the desertion to a fellow practitioner demanded a personal explanation. The physician "built up" a fairly stable practice; he commanded a regular but rather modest income; he knew rather intimately the circumstances of his patients, and tempered his none-too-collectable charges with a studied neglect. In the relations between physician and patient, accounts were kept and money was passed; but, even though individuals might often depart from their ideals, the circumstances of the times and the ethics of the profession kept medicine rather free of commercialism.

If there has been a change, the physician is not primarily to blame. On the contrary, it is a tribute to the profession that the older idealism has exhibited such persistence in an unfavorable environment. The fault—if fault there be—is that the profession has now to be practiced in an industrial world dominated by business. Doctors, like others, must maintain standards of living, give opportunities to their children, and provide security for old age. They must have money incomes, and incomes are to be had by securing and holding patients in rivalry with their fellows. The result is that the pressure from the system within which they must live and work is slowly and insidiously, but rather surely, bringing to the physician a consciousness of his own pecuniary interests, making something more of a business man out of him, and converting the thing once called "private practice" into a system of individual business competition. The institution of medical business enterprise was never developed within the profession; it is an importation from the commercial world, at first tolerated, and then accepted, because there seemed to be no way to avoid it. Its very character is out of harmony with the spirit of the profession.

The incidence of competitive medical enterprise falls heavily upon all the parties concerned. Although "the personal choice of a physician" is an excellent ideal, it does not, under current conditions, work well in practice. An old maxim, long known to every student of social philosophy, calls for a restriction of personal choice when "the consumer is not a proper judge of the quality of the ware." The art of medicine is intricate; the relation of the treatment of the sick to results obtained cannot be appraised by a layman; in medicine, almost more cer-

tainly than anywhere else, the patient has not the knowledge requisite for judgment. In almost every city reputable physicians will admit—at least in private—that the competence of their fellows is not in accord with their respective reputations. However free the choice seems to be, it has its practical limit in available knowledge; and that patient usually does best who seeks advice from a professional. Values are treasured long after they have begun to depreciate; and the idea of “free choice” is much too individualistic to be easily surrendered. But its worth is to a large extent fictitious; and the expense and suffering which attends wrong choice and “shopping around” add greatly to the avoidable human costs of medicine.

Nor is the system of individual business enterprise fair to the practitioner. It gives him, if he is skillful or lucky, an opportunity to increase his practice, to extend his services, and to win a fair competence. It grants him a chance—hardly comparable with that of the banker, the business man, or even the lawyer—of winning an estate. But it forces him to practice his profession under the arrangements of an alien trade, to make his services to some extent articles of merchandise, and to respond so far as his standards permit to the acquisitive incentives of business. He cannot do his work in a conscientious way and have his competence appraised and his performance rewarded by colleagues who are competent to judge. Instead income, security, and advancement come to him—if they come at all—as the results of the expansion of a business and through the favor of a laity who do not possess rational standards of judgment. The situation makes it difficult for a physician to earn a living in a business community without yielding to its usages; and the stress and strain to which the code of medical ethics has of late been put indicates the difficulties by which the practitioner is being beset. Nor in an industrial community, in which livings are insecure, incomes are inadequate, and the doctor is almost the last to be paid, is the pressure likely to diminish. A great deal is now being said about “the rewards of private practice” as an urge to “the display of talents.” But the case for acquisition as an incentive rests rather upon assertion than upon proof. We cannot know for certain; but I suspect that, aside from the alleviation of suffering, the strongest impulse which moves the physician is the professional motive of winning the

esteem of his fellows. And I am inclined to believe that the ordinary physician is an artist who esteems, far more highly than the dubious chance at wealth, a regular and an adequate income, the feeling of security, and freedom to devote himself in an uncompromising way to his calling. The medical profession has, from time out of mind, disclaimed the acquisitive motive. If it is to be true to its high calling, the interests of patients and of physicians alike demand that it be kept out of business.

Here is the heart of the problem of the organization of medicine. A profession has, quite by an historical accident which was not foreseen, fallen into a world of business and is making the adaptation which seems necessary to survival. It has all come about so slowly and so much by stealth that the program of control essential to the maintenance of the integrity of the traditional ideal could not be formulated. As a result the older order of "private practice" is being transformed into a system of competitive enterprise, which no one has consciously willed and which in insidious ways interferes with the great social task which medicine is to perform. In a pre-industrial era, medicine in the hands of private practitioners was a "public service." In the modern industrial world business enterprise must be sacrificed, if need be, in order that medicine may remain—or again become—a public service. The older ideals must persist, even at the cost of giving up an instrumentality which has proved valuable. This end is paramount; and I believe it can be attained only by a complete elimination of the aims and the arrangements for profit-making from the practice of the art. This brief statement allows little in the way of detail, but a mere outline may give something of a concrete picture of what an adequate medical service must be.

It must, it is hardly necessary to say, comprehend the whole population. A division of labor on a continental scale has bound the fortunes of each of us with the operation of an intricate industrial system and has made us inseparably "members one of another." This interdependence has made the maintenance of the "common health" a public necessity as well as a social duty. If we are to make the most of our human resources, for work and for life, it is necessary that our facilities for health shall be just as available for all who need

them as are the schools and the churches. Nor should the matter of a membership in a health service be left to the free choice of the individual. The "reasonable man" of our ancestors, who was prudent and provident and would always seek his own best advantage, now lives only as a fiction. To the myth I should make the concession of a semblance of a choice to mask the fact of compulsion. The matter has some importance; business succeeds rather better than the state in imposing its restraints upon individuals, because its imperatives are disguised as choices. But in essence the opportunity must be compulsory; for men have little capacity to organize in advance the conditions under which they live together; yet, once a new system is established, they easily accommodate their activities to it.

So, it seems to me, that the scheme called compulsory health insurance is the very minimum which this Committee should have recommended. Its irregular incidence, and the practical difficulties in the way of budgeting, make necessary some type of collective provision against sickness. Furthermore, we have not as yet found a way to assure to all workers a minimum wage or to abolish insecurity from the economic order; and, so long as income is fitful and uncertain, it cannot provide an adequate basis for the financial maintenance of medical services. Besides, for a long time to come we are to have with us, groups whose meager incomes will permit no contribution to a fund for the maintenance of health. In this scheme I should be disposed to attempt to accommodate the venerable principle of medicine, "to each according to his needs, from each according to his ability to pay," to modern conditions. The service should be available to all, either without charge, or upon the payment of a small fee designed to prevent frivolous use. All members should pay an annual charge towards the support of the service. A person belonging to the lower income group would pay only a nominal amount; a person with a moderate income would be assessed at a rate which would make the venture self-supporting; persons in the higher income groups should be taxed at graduated rates in accordance with the traditional principle of the sliding scale. The whole would represent an accommodation of the traditional system of medical payment to the conditions of the modern world in which we live.

As is recommended in the Report, all services would be dispensed from a medical center. The private practice of an isolated physician is one thing; the practice of an individual, whose work is supplemented by specialists, and who has access to laboratories and hospitals, is quite another. The medical group has come to stay, whether we like it or not; the current questions of importance relate to its service, its control, and the rate of its extension. A rural area, or a small town with the surrounding country, should have a single center; a larger city might have a number. Each should be organized as a corporation; the board of trustees, which legally is to have formal authority, should be composed of laymen, no one of whom has any pecuniary interest in the venture. The professional staff, composed of physicians and surgeons, should have complete control over all the medical services of the center. All appointments should be made by the board of trustees upon recommendation of the staff. All officers and officials should be paid by salary; and all promotions should be based upon attested medical competence. The staff should consist of one or more general practitioners, the specialists for whose services there is a full and regular demand, and subordinate functionaries. Diagnosis and a regimen of treatment lie at the heart of medical service; the key-position, therefore, should—as is recommended in the Report of the majority—be accorded to the general practitioner, who should be a man of broad training and wide experience. The specialist should take his proper place as an auxiliary; and the mere technician should be accorded only the subordinate place for which his limited competence and detailed task fits him. The smaller centers must, of course, depend upon the larger ones nearby for the unusual or auxiliary services which it is not expedient for them to attempt to offer. The scheme of organization should parallel the type currently in vogue in the universities. The corporation should have power to set aside reserves, establish pension funds, and take other financial precautions. But it should not pay out dividends or engage in any form of profit-making. In its larger outlines this scheme of organization is not a novelty; it is adapted to a profession engaged in a public service; its value has been attested by its employment in education.

The problem of the larger control invites no categorical

answer. In any such scheme the authority of the state must be invoked to make membership compulsory and to insure the collection of personal assessment. If a graduated assessment is imposed upon higher income, the power of taxation may have to be used as a necessary means. The state, too, may have to be employed to divert income from financially able centers to poorer ones whose existence depends upon a subsidy. But, if it can be done, it is to be hoped that the concern of the state in the venture can be limited to a use of its power of compulsion in financial matters. A way, maybe a number of alternative ways, can be contrived, to allow the community, acting independently of the government, to manage its own medical center. A scheme, for instance, might easily be devised by which the supporting members might elect the board of trustees. But even if the venture goes forward under the auspices of the state, the separate corporation with its distinct control, insures semi-independence. And, if it is eventually found necessary to give to the government a larger authority, the outcome need not be viewed with alarm. A public body charged with important tasks is likely to be more closely watched than one to whom only trifling matters are entrusted. Besides, the state has not had a good press agent, and, now that we have experienced depression, we talk much less glibly than once we did about the efficiency with which business manages the social tasks which have been entrusted to its charge.

It is not for me to dogmatise about ways and means through which all this is to be brought to pass. In the scheme as outlined there is the largest place for local autonomy and local control. We must build upon the resources in personnel, in buildings and equipment, and in prevailing sentiment and opinion which already we possess. Our American communities differ materially one from another; and, within the flexible confines of this scheme, there is room for a large number of very distinctive sets of arrangements. Current projects which might easily be accommodated to the form, present a wide variety. Besides, the technology of medicine may be well developed; but the art of its organization is still in its infancy. We need to experiment, to find out new devices and procedures, and to combine them in organizations which may be vastly superior to anything which as yet we have tried.

It will be argued that all of this suggests an eventual and not an immediate objective; that it can be brought about, not by giving effect to recommendations, but only by the realization of a program. All of this is quite true; the medical center cannot be made adequately to perform its function until there has grown up about its mechanical structure a cluster of usages, established in the habits of its staff and the public which it serves, which will make it a living institution. But it does not follow that its compulsory establishment by the state should be deferred. It sounds reasonable to insist upon the establishment of the necessary customs and habits in advance, and so gradually to approach the objective. But, as matters go, the preliminary movements are likely to be lost in the course of events long before they have established a foundation for larger things. The more practical course would seem to be to set up the system and allow the usages essential to its success to grow up about it. The initial cost in malperformance and readjustment would be a small price to pay for a system of medical care adjusted by trial and error to the function it was called on to perform. After all, the catastrophic course of events hurries boldly on; it is only man who follows diffidently with his timid controls.

As the Report phrases it, the adventitious system upon which we depend for the maintenance of health is a "challenge to the future." Whether we allow the prevailing system to go its undirected way, or whether we attempt to impose order and purpose upon it, we must take a chance. But "all life is a chance" and from the hazards which attend any institution contrived for the performance of a social function there is no escape. The evidence presented in the many published studies of the Committee made it evident that an attempt to patch up a system is not a promising venture. The disorder and the diversion from purpose which characterize it make the current organization of medicine an insecure foundation on which to build an adequate and an enduring service. A resort to palliatives in an effort to make it work can only lead to a continuance of the present appalling waste in human resources. The turbulent stream of change which hurries us towards an unknown future is not going to be stayed while we cautiously tinker and solemnly debate the next step. The plain truth is that, rich as the country is in potential wealth, the haphazard system of

private medical enterprise is a luxury we cannot afford. In a society in which the lives and fortunes of all are mutually interdependent, the maintenance of the physical welfare of the people must be a public function. We must consider ways and means; we must take careful thought, and planning must precede action. It is only a venture which promises the conservation of "the common health" which is worthy of the values which are the stakes. If we are to have what may be ours, we must be wise and bold.

WALTON H. HAMILTON.

STATEMENT

BY

EDGAR SYDENSTRICKER

As a member of the Committee, I regret that I cannot see my way clear to sign the final report of the Committee for the reason that the recommendations do not, in my opinion, deal adequately with the fundamental economic question which the Committee was formed primarily to study and consider.

EDGAR SYDENSTRICKER.

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Organized to study the economic aspects of the prevention and care of sickness, including the adequacy, availability, and compensation of the persons and agencies concerned

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* Deceased.

† Resigned.

WALTON H. HAMILTON, PH.D., Professor of Law, Yale University Law School, New Haven, Connecticut.

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- †6. A SURVEY OF THE MEDICAL FACILITIES OF SHELBY COUNTY, INDIANA: 1929. By Allon Peebles, PH.D. 213 pages. June, 1930. Paper, \$1.00.
- †7. CAPITAL INVESTMENT IN HOSPITALS: The Place of "Fixed Charges" in Hospital Financing and Costs. By C. Rufus Rorem, PH.D., C.P.A. 44 pages. November, 1930. Paper, 25 cents.
- †8. PRIVATE GROUP CLINICS: The Administrative and Economic Aspects of Group Medical Practice, as Represented in the Policies and Procedures of 55 Private Associations of Medical Practitioners. By C. Rufus Rorem, PH.D., C.P.A. 130 pages. January, 1931. Paper, 75 cents.
- ✓†9. A SURVEY OF THE MEDICAL FACILITIES OF THE CITY OF PHILADELPHIA: 1929: Being in Part a Digest of the *Philadelphia Hospital and Health Survey, 1929*. By Nathan Sinai, D.P.H., and Alden B. Mills. 298 pages. July, 1931. Paper, \$1.50.
- †10. A STUDY OF PHYSICIANS AND DENTISTS IN DETROIT: 1929. By Nathan Sinai, D.P.H., and Alden B. Mills. 54 pages. March, 1931. Paper, 25 cents.
- ✓†11. THE "MUNICIPAL DOCTOR" SYSTEM IN RURAL SASKATCHEWAN. By C. Rufus Rorem, PH.D., C.P.A. 84 pages. July, 1931. Paper, \$1.00.
- †12. A SURVEY OF THE MEDICAL FACILITIES OF SAN JOAQUIN COUNTY, CALIFORNIA: 1929. By Nathan Sinai, D.P.H., *et al.* 230 pages. October, 1931. Paper, \$1.00.
- ✓†13. A SURVEY OF THE MEDICAL FACILITIES OF THE STATE OF VERMONT. By Allon Peebles, PH.D. 340 pages. January, 1932. Paper, \$1.50.

* Copies of Publications Number 1 to 8, inclusive, and 10 may be obtained free of charge from the Committee on the Costs of Medical Care until the supply is exhausted. All publications listed may be obtained at the specified prices from the University of Chicago Press, 5750 Ellis Avenue, Chicago, Illinois.

† A brief abstract of this report is available to interested persons upon request.

‡ The full report, of which this publication is a digest, is available in the following volume: *The Public's Investment in Hospitals*, by C. Rufus Rorem. University of Chicago Press. 251 pages. November, 1930. Cloth, \$2.50.

- †14. **THE COSTS OF MEDICINES: The Manufacture and Distribution of Drugs and Medicines in the United States and the Services of Pharmacy in Medical Care.** By C. Rufus Rorem, PH.D., C.P.A., and Robert P. Fischelis, B.S., PHAR.D. 268 pages. April, 1932. Cloth, \$2.50.
- †15. **MIDWIVES, CHIROPODISTS, AND OPTOMETRISTS: Their Place in Medical Care.** By Louis S. Reed, PH.D. 83 pages. March, 1932. Paper, \$1.00.
- †16. **THE HEALING CULTS; A Study of Sectarian Medical Practice: Its Extent, Causes, and Control.** By Louis S. Reed, PH.D. 148 pages. March, 1932. Cloth, \$2.00.
- †17. **NURSING SERVICES AND INSURANCE FOR MEDICAL CARE IN BRATTLEBORO, VERMONT: A study of the Activities of the Thomas Thompson Trust.** By Allon Peebles, PH.D., and Valeria D. McDermott. With an Evaluation of the Nursing Program, by Violet H. Hodgson, R.N., Assistant Director, and Katharine Tucker, R.N., General Director, of the National Organization for Public Health Nursing. 78 pages. July, 1932. Paper, 60 cents.
- †18. **THE MEDICAL SERVICE OF THE HOMESTAKE MINING COMPANY: A Survey of a Community Medical Service Operated Under Industrial Auspices.** By Louis S. Reed, PH.D. 66 pages. August, 1932. Paper, 60 cents.
- †19. **UNIVERSITY STUDENT HEALTH SERVICES: A Study of Organization, Services Rendered, and Costs in Cornell University, Yale University, the University of Michigan, the University of Minnesota, the University of California, and Oregon State Agricultural College.** By Don M. Griswold, M.D., DR.P.H., and Hazel I. Spicer. 129 pages. September, 1932. Paper, 90 cents.
- †20. **A COMMUNITY MEDICAL SERVICE ORGANIZED UNDER INDUSTRIAL AUSPICES IN ROANOKE RAPIDS, NORTH CAROLINA.** By I. S. Falk, PH.D., Don M. Griswold, M.D., DR.P.H., and Hazel I. Spicer. With Reports on Certain Phases of the Organization, by David Riesman, M.D., S.C.D., and George P. Muller, M.D. 126 pages. September, 1932. Paper, 90 cents.
- †21. **ORGANIZED MEDICAL SERVICE AT FORT BENNING, GEORGIA.** By I. S. Falk, PH.D. With Reports on Certain Phases of the Organization, by David Riesman, M.D., S.C.D., and George P. Muller, M.D. 136 pages. November, 1932. Paper, 90 cents.
- †22. **THE FUNDAMENTALS OF GOOD MEDICAL CARE: An Outline of the Fundamentals of Good Medical Care and an Estimate of the Service Required to Supply the Medical Needs of the United States.** By Roger I. Lee, M.D., and Lewis Webster Jones, PH.D., with the assistance of Barbara Jones. 250 pages. November, 1932. Cloth, \$2.00.
- †23. **SURVEYS OF THE MEDICAL FACILITIES IN THREE REPRESENTATIVE SOUTHERN COUNTIES.** By C. St. C. Guild, M.D., DR.P.H. With a Statistical Appendix on the Method of Selecting Representative Counties, by I. S. Falk, PH.D. 150 pages. November, 1932. Paper, \$1.00.
- †24. **THE INCOMES OF PHYSICIANS: An Economic and Statistical Analysis.** By Maurice Leven, PH.D. 150 pages. November, 1932. Cloth, \$2.00.

† A brief abstract of this report is available to interested persons upon request.

‡ Brief abstracts of Publications No. 17 to 21, inclusive, appear as a unit under the title *Surveys of Organized Medical Service*. This composite abstract is available to interested persons upon request.

- ✓ †25. THE ABILITY TO PAY FOR MEDICAL CARE. By Louis S. Reed, PH.D. (In Preparation.)
- ✓ †26. THE INCIDENCE OF ILLNESS AND THE RECEIPT AND COSTS OF MEDICAL CARE AMONG REPRESENTATIVE FAMILIES: Experiences in Twelve Consecutive Months During 1928-1931. By I. S. Falk, PH.D., Margaret C. Klem, and Nathan Sinai, D.P.H. (In Preparation.)
- ✓ †27. THE COSTS OF MEDICAL CARE: The Economic Aspects of the Prevention and Care of Illness. By I. S. Falk, PH.D., C. Rufus Rorem, PH.D., C.P.A., and Martha D. Ring. (In Preparation.)
- †28. MEDICAL CARE FOR THE AMERICAN PEOPLE: The Final Report of the Committee on the Costs of Medical Care. 236 pages. November, 1932. Cloth, \$1.50.

Abstracts of Reports Published by Collaborating Agencies

- C1. DENTAL PRACTICE AND INCOME. By Maurice Leven, PH.D., Based Upon Data Collected Under the Direction of Dorothy Fahs Beck. †
- C2. THE PURCHASE OF MEDICAL CARE THROUGH FIXED, PERIODIC PAYMENTS. By Pierce Williams. §

Miscellaneous Contributions on the Costs of Medical Care

- 1. INSTITUTIONAL CONVALESCENCE. By E. H. Lewinski Corwin, PH.D.
- 2. THE COSTS OF MEDICAL CARE TO 4,560 FAMILIES: Preliminary Report. By Nathan Sinai, D.P.H., and Margaret Klem.
- 3. FUNERAL COSTS. By John C. Gebhart.
- 4. THE RELATIONS OF MEDICAL MEN AND HEALTH OFFICIALS. By W. S. Rankin, M.D.
- 5. THE USE OF SMALL LOANS FOR MEDICAL EXPENSES. By Leon Henderson.
- 6. THE MASSACHUSETTS CANCER PROGRAM. By George H. Bigelow, M.D.
- 7. MEDICAL CARE IN MIDDLETOWN. By Robert S. Lynd and Helen Merrell Lynd.
- 8. THE NEED FOR COMPETENT HOSPITAL DIRECTORS. By Michael M. Davis, PH.D.
- 9. THE RELATIONS OF ILLNESS AND DEPENDENCY. By Frank J. Bruno.
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- 11. THE EXTENT AND ADEQUACY OF LIFE INSURANCE PROTECTION IN THE UNITED STATES. By Mary Dublin.
- 12. HEALTH COUNCILS. By Howard W. Groen.
- 13. THE VOLUNTARY HEALTH INSURANCE OFFERED BY THE ROSS-LOOS CLINIC OF LOS ANGELES. By Alden B. Mills and C. St. C. Guild, M.D., DR.P.H. (In Preparation.)
- 14. PUBLIC HEALTH NURSING SERVICE IN THE UNITED STATES. By Katharine Tucker and the Staff of the National Organization for Public Health Nursing. (In Preparation.)
- 15. THE BIGGS HEALTH CENTER PLANS: State Aid for Local Health Work in New York. By Alden B. Mills. (In Preparation.)

† A brief abstract of this report is available to interested persons upon request.

‡ An Abstract of *The Practice of Dentistry and the Incomes of Dentists in Twenty States: 1929*, by Maurice Leven, Ph.D., of the Research Staff of the Committee on the Costs of Medical Care, Based on Schedules Procured Under the Direction of Dorothy Fahs Beck of the Research Staff of the Committee on the Study of Dental Practice of the American Dental Association. The University of Chicago Press, Chicago, Illinois. 224 pages, February, 1932. Cloth, \$2.00.

§ An Abstract of *The Purchase of Medical Care Through Fixed Periodic Payments*, by Pierce Williams. The National Bureau of Economic Research, Inc. New York, July, 1932. 800 pages. Cloth, \$3.00.

LIST OF PUBLICATIONS OF AGENCIES COLLABORATING WITH
THE COMMITTEE ON THE COSTS OF MEDICAL CARE

The American Dental Association

- *THE PRACTICE OF DENTISTRY AND THE INCOMES OF DENTISTS IN TWENTY STATES. By Maurice Leven. February, 1932.
- THE COST OF EQUIPPING A DENTAL OFFICE. By Dorothy Fahs Beck. February, 1932.
- A STUDY OF DENTAL CLINICS IN THE UNITED STATES: 1930. By Miriam Simons Leuck. February, 1932.
- A FURTHER STUDY OF DENTAL CLINICS IN THE UNITED STATES. By Miriam Simons Leuck. (In preparation.)
- THE COSTS OF DENTAL EDUCATION. By Miriam Simons Leuck. (In preparation.)
- THE WAY OF HEALTH INSURANCE. By A. M. Simons and Nathan Sinai. April, 1932.
- SUMMARY OF THE FACTS PERTAINING TO DENTISTRY CONTAINED IN THE PUBLISHED REPORTS OF THE COMMITTEE ON THE COSTS OF MEDICAL CARE. By Dorothy Fahs Beck. Journal of the American Dental Association, February, 1932, pages 230-251.

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- THE COSTS OF MEDICAL EDUCATION, STUDENTS' EXPENDITURES. By R. G. Leland, Journal of the American Medical Association, February 28, 1931, pages 682-90.
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- THE COST OF MEDICAL CARE. By Lee K. Frankel, January, 1930.
- A STUDY OF SICKNESS COST AND PRIVATE MEDICAL PRACTICE. By Donald B. Armstrong, May, 1932.
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- *THE PURCHASE OF MEDICAL CARE THROUGH FIXED PERIODIC PAYMENT. By Pierce Williams. 1932.

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* A brief abstract of this report is available to interested persons upon request.

The Milbank Memorial Fund

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