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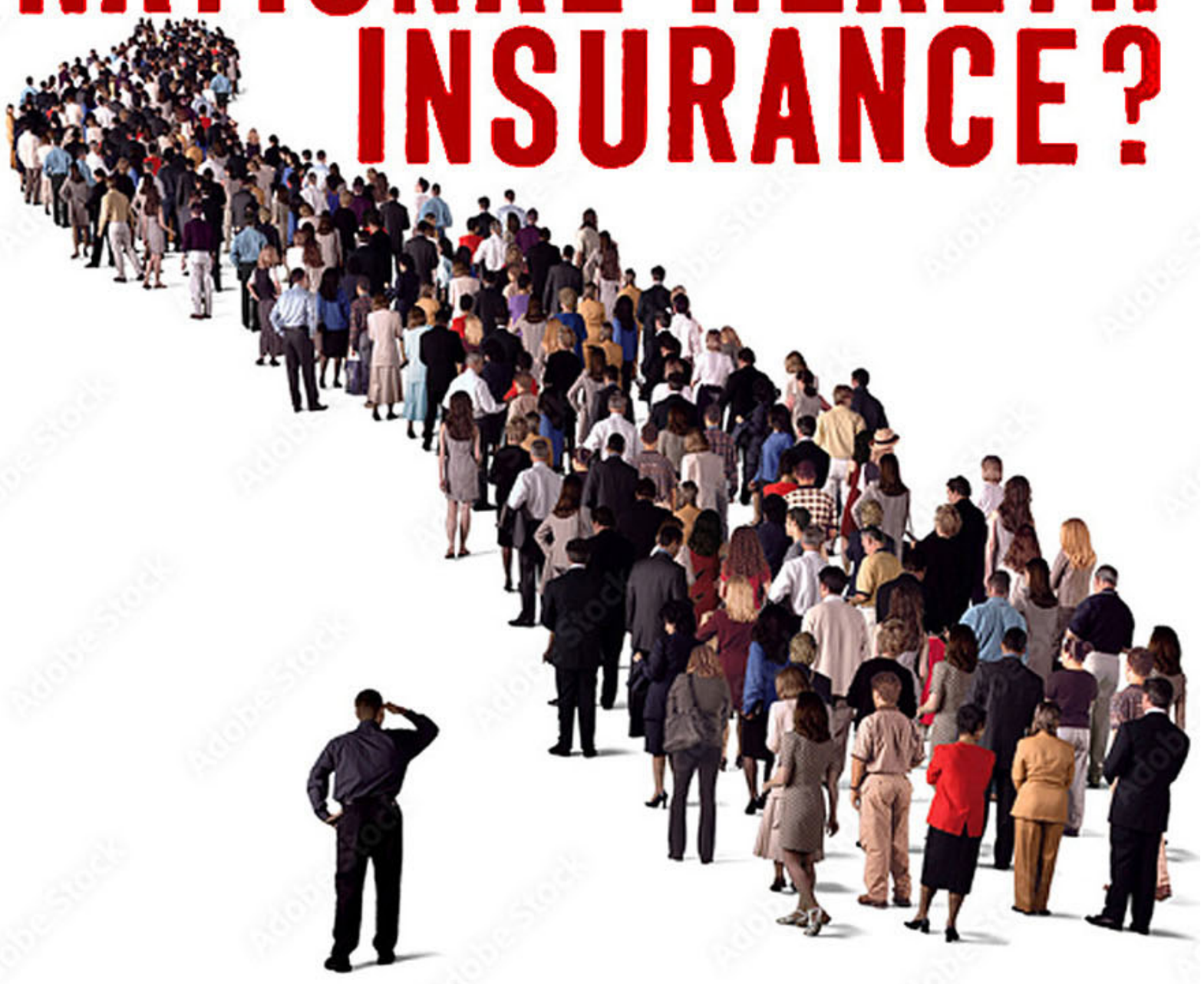
DO WE WANT NATIONAL HEALTH INSURANCE?



Congress will soon face the question of how we should try to improve our health, and here are the arguments which will be heard from friends and foes of the revised Wagner bill

by Amy Porter

THE state of health in the United States is nothing to brag about. Ours is not the healthiest country in the world, although we like to think it is. In the matter of life expectancy, often taken as an index of health, the U.S. does not make a very good showing. Prewar statistics, compiled by the National Resources Planning Board, reveal that we are outranked in life expectancy at various ages by Norway, Sweden, Denmark, the Netherlands, Australia, New Zealand, Germany, Italy and other countries. At age sixty, we rank below eleven other countries.

We lose at least half a billion working days each year to illness, one third of it considered preventable. Out of 13 million men drafted, almost four million were rejected as unfit. Of the unfit, at least one sixth suffered from "easily remedied defects," and a larger proportion from defects that were preventable. Methods and treatment are steadily improving, yet it is estimated that from 30 to 50 per cent more mothers die than would die if they all had good medical care. With proper treatment, probably 30,000 cancer victims could be saved each year. Syphilis could be wiped out with the knowledge we now have and do not fully apply; and tuberculosis, which claimed more than 56,000 lives in 1943, could be practically eliminated.

These statistics and estimates come from the U.S. Census Bureau, the U.S. Public Health Service, the Children's Bureau and other governmental agencies, and from studies made by private agencies such as the Rockefeller Foundation. A survey by the Committee on the Costs of Medical Care showed that at the peak of prosperity in 1929, one half the population was poorly provided with medical care. This result is borne out by the findings of the National Health Survey, made during the depression.

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Dr. Morris Fishbein, American Medical Association spokesman and bitter opponent of national health insurance, says: "Under our system of free enterprise many plans for providing adequate medical care are being developed without paying the price of governmental control and socialized medicine"

When people do not get adequate care, it generally is because they cannot afford it. Medicine is more effective and more widely applied today than it used to be, but full application is often more costly because it makes frequent use of expensive equipment, expensive laboratory procedures and expensive consultations with specialists.

Doctor Ernst Boas, of Columbia University's College of Physicians and Surgeons, says: "Medical knowledge has increased so much, it costs more to apply it. This is not the doctor's fault and it is not the people's fault. But we must find a remedy. Fifty years ago a man with a bellyache was content when his doctor gave him a few pills out of his little black bag. That was all there was to do for him, and it didn't cost too much.

"Now, the man who takes his bellyache to the doctor may get involved in X-rays and specialists and one thing or another until the first thing he knows he has run up a bill for $50 or $100 or $1,000. Or else, realizing he may run up such a bill, he stays away from the doctor, taking his chances on a ruptured appendix or stomach ulcers. And when you consider the cost of caring for long-drawn-out illness, such as rheumatism or heart trouble or cancer—well, we all know cases where such costs have brought a family to ruin."

Lack of money is the reason, again, for the scarcity of doctors in farm communities and in the poorer sections of the country, especially the South. This scarcity is not merely a wartime condition but a settled trend which can be expected to continue after the war. Doctors in private practice must live by fees, so naturally most of them gravitate to cities and prosperous communities where more people have more money. In peacetime, New York—a center for specialists—had one doctor for every 487 inhabitants. But Alabama had one doctor for every 1,500 inhabitants (since the war, one for every 2,800).

The regions that are short of doctors usually have too few hospitals and inadequate

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Dr. Ernst Boas, head of a group of AMA doctors actively working for passage of the Wagner bill, says: "Fully 50 percent of our population cannot afford to buy adequate medical service and do not receive it. . . . Medicine, run as a private enterprise for the benefit of the doctors, is not meet the problem and cannot meet it. Only national health insurance can meet it. The proposal is not to socialize medicine but to spread its benefits to all"

supplies and facilities such as X-ray services and laboratories. This, in turn, keeps doctors away, for a modern doctor prefers to practice with the aid of the equipment he learned to depend upon at medical school.

In general, the distribution of medical care in this country is spotty, with the well-to-do and sometimes the city poor getting good care, and the middle and lower income groups, especially in rural areas, often getting inadequate care, or no care at all. This spotty distribution is reflected in various statistics. Last year 200,000 women gave birth to babies without any medical help. Out of every 1,000 babies born in the United States, 40 die during their first year of life, but that is the rate for the country as a whole. In ten states, only about 30 babies out of every 1,000 fail to live out their first year. At the same time, in ten other states, the infant death rate was nearly double the average for the best states.

In the ten states where the fewest babies died, over four fifths of the births occurred in hospitals. Physicians attended nearly every birth. But in the ten states where almost twice as many babies died, less than a third of the births were in hospitals, and only about three fourths were attended by doctors. In the same way, the poorer areas of any city will fall behind the city as a whole in health.

We all know these things in a vague sort of way. We shudder when some especially pathetic case is brought to our attention through a newspaper story or through per-

sonal knowledge. We shudder and perhaps we send in a contribution to a health fund.

We Americans, who can boast of the finest doctors and hospitals in the world, do not like to think that our neighbors actually suffer and die because they do not have access to good medical care. Doctor Alan Gregg, medical director of the Rockefeller Foundation, says, "Because the doctor's services are purchaseable and yet almost beyond price, they are coming to be regarded like life, liberty and the pursuit of happiness—a civic right, a public necessity."

It is generally agreed that something must be done—and nearly everyone concerned with the problem agrees that that something will have to be insurance of one kind or another, public or private. Individually, most people cannot budget the unpredictable costs of illness. Collectively, they can do it in the same way they budget fire or car insurance.

The most far-reaching insurance proposal so far is the Wagner-Murray-Dingell Social Security bill, a revised version of which is to be considered by the present Congress. In its medical provisions, the bill goes beyond all earlier ones and proposes to pay the cost of complete medical and hospital care for some 110,000,000 U.S. citizens, from birth to death, from measles to eyeglasses.

The measure proposes to pay for this and other health measures with the expenditure of approximately the same amount of money, or perhaps a little more, than we pay out now for private medical services—between two and three billion dollars. The money would come from insurance taxes instead of through fees paid privately to doctors and hospitals. All of us, sick and well, rich and poor, would pay according to our earnings to make up a great insurance fund out of which all of our medical needs would be met.

The medical provisions are the most controversial part of the bill, which is sponsored by Senators Robert F. Wagner and James E. Murray and Representative John D. Dingell, and is designed to extend social security all along the line. It provides for a single payroll deduction of 6 per cent on incomes up to $3,000, with employers paying a like amount. Self-employed persons such as grocers, farmers, doctors, would pay seven per cent. One quarter of the total funds would be applied to medical care costs, the balance going to insurance against old age, unemployment, maternity, temporary illness, permanent disability.

Thus, if you are employed, complete medical care for yourself and your dependents would cost you one and one half per cent of your income up to $3,000, or not more than $3.75 a month. An average, middle-income family now pays out 4 per cent of income on medical bills alone, or about $120 annually on $3,000. Of course, most of us would not pay the maximum $3.75 monthly, or $45 annually, for medical and hospital care, because three fourths of us make less than $3,000 a year.

The bill has passionate friends and violent foes. They have argued themselves hoarse since 1939 when the first compulsory health insurance proposals were put before Congress. The foes charge that the bill is

"Communistic," "un-American," "a stab at free enterprise," and a scheme to provide an inferior kind of "political medicine" to the people.

Led by the American Medical Association, they include several large national drug chains, some private insurance companies, a group of patent-medicine and drug manufacturers, the American Bar Association, and the American Hospital Association. Prominent doctors opposed to the bill include Doctor Morris Fishbein, editor of the AMA Journal, Doctor James C. McCann, president of the Massachusetts Medical Service, Doctor W. P. Morrill, research director, American Hospital Association, and many others.

The bill's friends argue that tax-supported medicine is no more un-American than tax-supported education.* They are led by the social-minded legislators who wrote it, and by a minority group of doctors within the American Medical Association. Friends include organized labor, both A.F. of L. and C.I.O., some farm groups, the National Lawyers' Guild, the Association of Interns and Medical Students, and the American Public Health Association. Prominent doctors and specialists who favor the bill include Doctor Hugh Cabot of Boston, formerly of the Mayo Clinic, Doctor Ernst Boas of Columbia University's College of Physicians and Surgeons; Doctor Miles Atkinson, eye, ear, nose and throat specialist, of New York University, and many others.

The arguments of the opposition are: 1) The bill would rob the patient of his right to choose his own doctor. 2) It would lower standards of medical care. 3) It would make doctors "slaves" to bureaucrats. 4) It would cut the doctor's income by ending the fee-for-service system. 5) The bill is unnecessary because anyone can get the medical care he needs right now, privately, or through voluntary insurance or through charity.

Those in favor of the bill reply that: 1) The bill does not limit free choice of physician, rather it extends the privilege to those who have not had much choice before. 2) Standards of care would be raised because a physician would be able to make free use of costly equipment, specialists' services, and laboratory tests which now are often beyond the ability of his patient to pay for. 3) Doctors would be as independent as they are at present, practicing as they do now, except that they would be sure of getting paid. 4) Most doctors' incomes would be raised, and those who wished to keep on with private practice could do so. 5) Many persons do not now get adequate care, either because they can't afford it and don't like to ask for charity or because first-rate medical services aren't available in the communities where they live.

*Doctor Fishbein of the American Medical Association says: "Take a look at tax-supported education.

"We have in the United States 108,000 one-room schools —in Illinois 67 per cent of educational facilities—where one teacher teaches all the subjects to pupils of all ages and acts at the same time as school nurse, physical educator and supervisor of recreation. Among the medical profession there is a feeling that national compulsory sickness insurance would provide an equally low quality of medical care for most of the people served."

Advocates of the Wagner bill reply that because the bill is national in scope, it would tend to eliminate state inequalities in health facilities, pulling up low-standard areas to higher standards.

Public opinion on the issue is reflected by various polls. Doctor George Gallup reports that 59 per cent of the people want an extension of Social Security laws to cover medical care. Seventy-five to eighty-five per cent want an easier method of paying doctor bills.

A survey by the National Opinion Research Center (paid for by a group in favor of the bill) found that 68 per cent favored a broadened Social Security law covering payments for doctor and hospital care, and 82 per cent wanted an easier way of paying medical bills. Another survey by the Opinion Research Corporation (paid for by a group opposed to the bill) showed only 37 per cent favoring a "federal government plan" for health security, although 63 per cent wanted some easier way of paying medical costs. The National Opinion Research Center blames the apparent discrepancy in the two surveys on the way the Opinion Research Corporation worded its questions.

The Wishes of the People

Still another poll, made by Foote, Cone & Belding for the California Medical Association to determine how doctors could meet the "threat of federal medicine," found that 50 per cent of California's citizens definitely favor federal medicine, 34 per cent are against it, and 16 per cent are undecided.

The report commented: "Among upper-income groups, federal medicine is desired because of the poor. Among the poor it is desired because they want proper care themselves. . . . If it were to come up on the ballot today . . . it seems abundantly clear that you (the California Medical Association) would lose the issue—perhaps by a landslide.

"And," the report continues, "if doctors ask, 'Why is medicine singled out? Hasn't the doctor as much right to the advantages of free enterprise as anyone else?' the answer is simple: 'The public doesn't think so.' The public is applying to the profession a principle as old as this nation: When something is desperately needed by all of the people, but only part of the people can obtain it because of the cost—then it must be socialized so that all may have it. The people quite evidently think that medicine should be a public utility under government control and operation like the postal system."

To wean the public away from "its desire for federal medicine," this firm advised its doctor clients to concentrate on enlarging and improving the California Physicians' Service, a medical insurance plan for families with incomes under $3,000. The California Physicians' Service is one of the best-known medical society-sponsored plans in the country, headed by the distinguished Doctor Ray Lyman Wilbur, chancellor of Stanford University, who had the boldness to suggest twelve years ago, when he was chairman of the Committee on the Costs of Medical Care, that it was time the American Medical Association did something to extend better care to low-income families.

The American Medical Association is conducting its campaign against the bill in co-operation with the National Physicians'

Committee, which has distributed more than fifteen million copies of a pamphlet denouncing compulsory health insurance.* This pamphlet, the committee states, "is the source and fountainhead of most of the propaganda against the Wagner bill, flooding the nation today. It supplies the chief arguments drummed into the medical profession through editorials in hundreds of official medical journals, and pounded into the public ear from the lecture platform, the press and the radio." Maybe you receive one of these pamphlets enclosed in your doctor's bill, or wrapped up with a package of pills at the drugstore.

The National Physicians' Committee also asks the personal physicians of congressmen to present its arguments to legislators. The National Physicians' Committee likens the "threat" of the Wagner bill to "a raging forest fire," and in one of its pamphlets says: "Human rights as opposed to state slavery is the issue. . . . The provisions (of the bill) are so sweeping that, if enacted into law, the entire system of American medical care would be destroyed."

The 1943 financial report of the committee noted that 6,227 individual physicians had sent in contributions "to preserve for the medical profession the independence and freedoms essential to its continued progress. . . ." The committee's funds for the fiscal year 1943-44 totaled $294,720.88.

Senator Wagner says of the National Physicians' Committee's pamphlets: "Misrepresentations and half-truths abound in this propaganda. It has roused unwarranted fears as to the purposes of our bill."

Wagner recalls the opposition he encountered when the Social Security bill was introduced in 1935. "Yet today," he says, "no one questions the value of this act."

Leaders of the American Medical Association, Doctor Morris Fishbein and others, say they speak for a majority of the country's doctors. Members include 125,000 out of a total of 185,000 licensed physicians.

But a dissenting group within the American Medical Association—the Physicians' Forum, headed by Doctor Boas of New York—is actively working for the Wagner bill. Another group of American Medical Association members—the Physicians' Committee for the Improvement of Medical Care, headed by Doctor John P. Peters of Yale University's medical school—endorses the principles of the Wagner bill. The combined membership of these two groups is around a thousand.

Doctor Boas argues: "You cannot tell from American Medical Association utterances how the rank and file of physicians feel. Many of them are afraid to speak up, for the American Medical Association is powerful. It can cause a doctor to lose his hospital privileges and otherwise damage him in his practice.

"We cannot win this fight through the organized doctors," Doctor Boas continues.

*Dr. Fishbein says the American Medical Association's house of delegates "has endorsed the work of this and other agencies," but that the American Medical Association does not support the National Physicians' Committee with funds. However, medical societies and individual doctors do support the NPC with funds.

"They'll trail along after their patients—the public—demand action. They have always trailed along behind every progressive move in medicine. They opposed public health vaccinations against diphtheria. They almost kicked me out of my county society because I ran a baby health station."

An opinion poll of doctors in the armed services shows, according to a report in the American Medical Association Journal, that 54 per cent want to go into group practice after the war, 4 per cent want to go into full-time salaried practice, and 5 per cent want to go into government service. Thus a total of 63 per cent prefer some form of practice other than the American Medical Association's traditional solo practice on a fee-for-service basis.

Fighting Fire with Fire

As one method of opposing the Wagner bill, leaders of the American Medical Association now are working to develop more and more voluntary insurance plans, such as the California Physicians' Service and other medical society plans, the Blue Cross Hospitalization plans, and industrial plans run by private insurance companies, in the hope that the public will prefer those to a government-sponsored nationwide plan.

Voluntary plans now promoted by organized medicine in the beginning were stoutly opposed by the American Medical Association. This century-old organization, which during its early history did so much to raise medical standards, promote research and stamp out quackery, thereby earning the gratitude and respect of the country, has always opposed any medical care plan that involved any change in the traditional way of practicing medicine. The traditional way is: The individual patient consults an individual doctor and pays a fee for each service rendered.

The American Medical Association disapproved of the first hospitalization plans, starting with the one that began in Dallas, Texas, in 1929, but later, after such plans were securely established in many places, it gave its approval. It opposed the country's three most famous voluntary medical insurance plans—Ross-Loos of Los Angeles (whose founders were expelled from their local American Medical Association); Group Health of Washington, D. C (which won a conviction in the Supreme Court against the American Medical Association under anti-trust laws), and Farmers Union Co-operative of Elk City, Oklahoma (whose founder almost lost his license to practice).

In the past it has opposed the formation of group practice centers where (as at the Mayo Clinic) a collection of doctors skilled in various branches of medicine work together to give appropriate care to each patient. It has usually protested when the government extended free treatment to special groups—such as venereal-disease cases, veterans, or low-income mothers and children—on the ground that such treatment amounted to

give appropriate care to each patient. It has usually protested when the government extended free treatment to special groups—such as venereal-disease cases, veterans, or

low-income mothers and children—on the ground that such treatment amounted to unfair competition with the private practitioners.

However, after national health proposals were introduced in Congress in 1939, the American Medical Association came to accept both group practice centers and voluntary insurance plans—although never a combination of the two. It also sanctions increased federal grants-in-aid to states, to provide public health services and care for indigents—always under local control.

There are at present over 300 voluntary insurance plans in operation—hospital, medical society, industrial and other types. Together they insure approximately 20 million people against one or more items of medical expense. The most important numerically are the Blue Cross hospital plans with an enrollment of 15 millions. These cover hospital bills only. About seven million people have some protection in addition to, or other than, hospitalization insurance. This protection, in about half the cases, is limited to surgical and obstetrical insurance, and, in many, there are other limitations.

So far, then, about 15 per cent of the population has signed up under voluntary plans of one kind or another. American Medical Association representatives believe this percentage can be tremendously increased. Advocates of the Wagner bill argue that experience shows such plans usually stop growing after a few years of operation, because the bulk of the people can't afford them.

The voluntary plans favored by medical societies and hospitals find most of their customers among people making over $2,000 a year, and even in the prosperous year 1942, 43 per cent of the nation's families earned less than $2,000. Then there is a "ceiling" on most plans, limiting membership to those with incomes of less than a specified amount. The ceiling is generally from $2,000 to $3,000. Most plans limit enrollments to group, many exclude dependents, almost all exclude persons over 60. For these and other self-limiting reasons, advocates of the Wagner bill believe voluntary schemes can never reach more than one fourth of the population. Also, as Wagner bill proponents observe, insurance against surgical and obstetrical expenses does not help a person who has pneumonia, heart trouble or cancer.

Those who administer voluntary plans are in general opposed to compulsory insurance. The Blue Cross administrators, closely affiliated with the American Hospital Association, which in turn is closely affiliated with the American Medical Association, are opposed. Mayor La Guardia of New York is an exception. He says that the new voluntary plan about to start operating in New York is "only a stopgap until something like the Wagner bill passes, and when that happens I'll be very happy about it."

The Wagner bill designates the Surgeon General as the administrator of its health insurance features. Would this mean, as opponents fear, that the Surgeon General would be an autocrat over American medicine, with

every doctor, every hospital, dependent on his whims?

Advocates say such fears are without foundation, since the bill provides suitable checks on the Surgeon General's power.

He could not *hire* doctors. Any doctor licensed to practice in any state would automatically have the right to participate in the national insurance plan if he wished to. And doctors would themselves decide which of several methods of payment they preferred.

On all matters of policy, the Surgeon General would be required to consult with a council on which the medical profession and other interested groups would be represented. He could not spend a penny without the consent of the Social Security Board, which, the bill's advocates argue, has made an excellent record for just, unbiased dealing during the ten years of its existence.

Under the bill, payment to doctors and hospitals would be arranged on a national basis, but administration of medical practice would remain, as now, a local affair.

To the argument that "government in medicine" would necessarily give us inefficient, low-quality care, Wagner bill advocates reply by citing the record of the many government health activities which have been in operation for years. The government now gives care to some 750,000 farmers through the Farm Security Administration. It gives whole or partial support in many states to public health departments, hospitals for veterans and for tubercular and mental cases, to venereal clinics, maternity and child health clinics.

Maternity clinics, for instance, have had the use of Social Security funds for the past seven years. From 1936 to 1942, the infant mortality rate was cut almost one third; the maternal death rate more than half. This marked decline coincides with the extension of medical services by the states, made possible in part by Social Security funds. Katharine B. Lenroot, chief of the Children's Bureau, says, "This federal aid was undoubtedly a factor in saving the lives of many babies and their mothers."

If the Wagner bill goes into effect, the voluntary plans will not necessarily be junked. Many probably will take over administration of the federal plan within their areas. At least one American Medical Association leader, in New Jersey, is figuring on that.

Speaking at a medical society meeting, he said, "We don't feel these plans are going to answer the problem of medical care distribution. If we took in 50 per cent of all the people in New Jersey, that wouldn't answer it. . . . But we can develop an agency . . . and its administrative methods can be extended to take over any federal plan which comes into our state. . . ."

The Health Program Conference of twenty-nine prominent physicians and economists issued a report in December, proposing that voluntary plans of good standard should be allowed to continue under a health insurance law. The Wagner plan has greater scope than any other. It offers more than insurance against the cost of illness.

"Ultimately and by evolution," Senator Murray says, "it probably would bring about a vast reorganization of medical care. It

would subsidize the building of hospitals, health centers and laboratories in the places that need them most. By offering doctors financial security (it is estimated that on the average the general practitioner would make at least $5,000; complete specialists twice as much) it would tempt an adequate number of able men to settle in areas now desperately in need of them.

New Era for Rural Doctors

"It would encourage establishment of group practice centers, on the theory that group practice offers the most efficient as well as the least expensive kind of medical care. Rural diagnostic centers would radiate out from these centers into small towns and rural areas. Thus the country doctor who never could afford to pay out $10,000 for three standard items—X-ray, cardiograph, and metabolism devices—would have access to this equipment."

The Wagner plan emphasizes preventive medicine. Doctor Atkinson of New York, praising this part of the program, said, "Any system of medical care which comes to life only in the face of illness is outmoded. If we are to give good care to all the people, we must prevent sickness, rather than simply treat sickness after it happens. This bill would encourage people to go to doctors for check-ups even when they feel well, thus making it possible for us, the doctors, to prevent illness and to detect serious disease while it is still in its early, curable, stages."

The bill also would provide funds for medical education and for medical research, both essential to continued progress.

Contrary to the fears of some doctors, private practice would not be wiped out. No doctor would be required to join the plan. The Park Avenue specialist and the super de luxe hospital could continue as now, giving luxury service to those who wish to pay for it. Just as we have many fine private schools in a country where tax-supported schools are open to everybody, so we would continue to have private doctors and private hospitals, along with assured medical care for everyone.

Senator Wagner says, "This is an American plan, geared to our own experience, form of government and standard of living. Our people need protection against the costs of illness. They need ways to narrow the gap between the best that medical science has to offer and what many people receive. The medical provisions of our bill provide this program."

Whether or not this particular bill is passed, the trend is in the direction of medical security for all the people. No country which has tried compulsory insurance has ever abandoned it. The organized doctors of Great Britain strongly favor more, rather than less, compulsory insurance. Perhaps, like some European countries, we will go through a period of further experimentation with voluntary plans before we come to a final decision on national health insurance.