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The Economic Future at Medical Practice

Leo C. Brown

The Economic Future of Medical Practice

Leo C. Brown, S.J.

About the author: Father Brown is Professor of Economics and Director of the Institute of Social Order of St. Louis University. For the past seventeen years he has been on the faculty there and in addition to a professorship in economics has held various administrative posts in the University.

During World War II he was a public member of the War Labor Board and the National Wage Stabilization Board in the Seventh Region. During the Korean incident he was a member of that Wage Board in the Ninth Region. He is presently a member of the Atomic Energy Labor-Management Relations Panel and since 1942 has been engaged in arbitration of labor disputes throughout the Midwest. On occasion he has mediated a number of protracted labor disputes.

*He received the A.B. degree in 1925, the A.M. in 1926, and the S.T.L. (a theological degree) in 1935, all from St. Louis University; and the Ph.D. in economics in 1940 from Harvard University. His writings include: **Union Policies in the Leather Industry**, Harvard 1947; **Impact of the New Labor Law on Union Management Relations**, ISO, 1943; Chapters in **Social Orientations**, Loyola 1954, and occasional articles.*

Here follows an address Father Brown gave to the Catholic Physicians' Guild of Detroit, in March of this year.

ONE OF THE difficulties a layman experiences in discussing a matter of common interest with a professional group is the lack of a common language of discourse. The private practice of medicine may connote one thing to doctors and another thing to laymen. Logically we should begin this exposition with a definition of private medical practice but I doubt that I can readily frame a definition which would be wholly acceptable to all.

Some in the profession equate private practice with individual practice, some extend the concept to include many forms of group practice, others are tolerant of a wide variety of forms as long as the free choice of physician is preserved, while still others would defend as private any form of practice which preserves the patient's choice of doctor and the physician's freedom in the exercise of his professional responsibilities and in deciding the amount and method of compensation. It seems best, therefore, to forego definitions and discuss the organization of future medical practice as it may be affected by current economic trends.

In the past half century important changes have occurred in medical practice. Even 25 years ago great advances in the deterioration and treatment of illness had vastly affected the structure of medical practice. With the developments which had then been achieved in bacteriology, in serology and radiology, specialization had become an important part of medical practice and the apparatus for diagnosis and treatment of disease required the outlay of substantial sums of capital. In recent decades this trend has continued at an accelerated rate. Today no

individual can hope to be truly proficient in more than one or two of the specialized medical fields and few if any can hope to acquire all the equipment needed for complete diagnosis and treatment. As a result, there has been a growing interdependence of the general practitioner and the specialist and greater reliance of both upon the facilities of specialized clinics and hospitals.

These changes have inevitably been reflected in the organization of medical practice. A recent survey found that only 56 per cent of practicing physicians are engaged in individual practice. Another 11 per cent have expense or space sharing arrangements; two-man partnerships account for nine per cent; large partnerships and groups for seven per cent; salaried assistantships for three per cent and other salaried forms of practice in hospitals, in industry or government, in universities and in clinics operated by consumer groups for 14 per cent.[1] These estimates take no account of physicians in military service.

What evidence there is suggests that the trend away from solo practice will accelerate. Only one of four medical students opts for strictly individual practice. Thirty per cent of those in training, as contrasted to 16 per cent of doctors today, want to practice in a partnership or in a group organized by physicians.

There has, indeed, been a movement away from individual and into group practice; yet, if we look at the phenomenon in perspective, the shift has been remarkably slow. Twenty-six years have elapsed since the Committee on the Costs of Medical Care recommended that medical service should be furnished largely by groups of physicians and other associated personnel, organized preferably around a hospital, and rendering complete home, office and hospital care.[2] Today, however, there are about 800 formally-organized groups with 12,000 of the country's 220,000 physicians.[3] About one-sixth of the groups are organized on a prepaid, service basis.

Its advocates explain the slow development of large group practice by pointing to the traditional conservatism of doctors, to the problem of agreeing upon division of revenue and to the capital needed to set up facilities.

This conservatism may be overstated. Doctors who carry an inescapable and continuing burden of decisions affecting the health and lives of their fellow men are understandably conservative about methods of treatment. On the other hand, there seems small reason why this attitude should deter them from considering methods of practice which do not endanger — which, their proponents affirm, actually improve — medical care.

In any form of shared practice, the problem of dividing income is real but this is one area in which the medical profession can claim no monopoly. Among close friends of mine in the legal profession one has been in two partnerships, another in three, in the past five years; the reason for the change in both cases has been the same — financial arrangements. This particular difficulty is probably outweighed by some of the advantages of group practice: the economy of shared space, better equipment and technical assistance and the ease of referral without risk of losing either the patient's confidence or custom.

The third reason offered for the reluctance to enter group practice — the initial costs involved — is, I suspect, the more important one. Many doctors, to whom this type of medical practice is attractive, lack the capital to establish the kind of facilities they regard as necessary or desirable. To the extent that initial cost has been an important obstacle to the growth of group practice, recent developments may alter the picture.

Experimentation in prepaid hospital and medical care on a large scale dates really only from the middle 1930s or early 1940s. The most important single factor in their development was the wage policy adopted by the government during World War II.

Insurance as fringe benefit

Wages were stabilized. With certain exceptions, employers could not grant wage increases which would put more money immediately in the pockets of employees. Non-inflationary fringe benefits were permitted, including pensions and health and welfare benefits. As one employer granted such benefits, others, competing in the tight labor market of those days, were forced to imitate him. And as one union successfully negotiated these benefits, other unions were forced to follow suit. The contract of the United Mine Workers in 1946 in which mine operators agreed to pay into a welfare and retirement fund five cents (now 40 cents) for every ton of coal mined, automatically set a standard for every union in mass production industries.

In 1948 the National Labor Relations Board in its famous Inland Steel decision held that pensions and a group insurance plan were "wages" and "conditions of employment" in the statutory sense and that employers were legally bound to bargain about them with the employees' bargaining agent, that is to say, with their union. In 1949 a Presidential Board of Inquiry in its report on a labor dispute in the steel industry concluded that

> industry . . . owes an obligation to the worker to provide for maintenance of the human body in the form of medical and similar benefits and full depreciation in the form of old-age retirement — in the same way as it does now for plant and machinery. This obligation is . . . one of the first charges before profits.[4]

These precedents and the pressures they put upon union representatives had by 1951 moved health and welfare benefits well toward the top of the priority lists in union negotiations.

The Korean War brought back wage stabilization. The Wage

[1] Clifford F. Taylor, "Tomorrow's Doctor Won't Go It Alone," *Medical Economics*, September, 1957, p. 306.

[2] *Medical Care for the American People*, University of Chicago Press, 1932, p. 109.

[3] A. Deutsch, "Group Medicine," *Consumer Reports*, January, 1957, p. 37.

[4] "Report to the President . . . on the Labor Dispute in the Basic Steel Industry." Washington, U.S. Government Printing Office, 1949. See also, "The Report of the President's Steel Industry Board," *Monthly Labor Review*, November, 1949, 69, p. 509.

Stabilization Board ruled, however, that inclusion of health and welfare benefits in labor agreements did not conflict with the government's policy of holding the line on wages. This ruling stimulated a rapid growth of health and welfare plans in union establishments with even nonunion establishments finding it either necessary or desirable to make similar provision for their employees. By 1952 unions, perhaps to their surprise (in some instances to their dismay), were solidly established in the health and welfare business.

Progress, however, in industry and by regions was uneven. Higher percentages of workers were covered by health insurance in manufacturing than in the service industries; coverage typically was higher in the middle West and middle Atlantic states than in the South and far West. In Detroit, for example, by 1952, 90 per cent of workers in manufacturing had some coverage, while the corresponding percentage in the service trades was 38. This may be compared with 46 per cent of workers covered in manufacturing and 19 per cent in services in New Orleans; and with 64.5 per cent in manufacturing and 58.4 per cent in services in San Francisco-Oakland in 1952.[5]

It should not be inferred that the 120 million-plus Americans or even a majority of them who now have some form of health insurance are members of unions; neither is it claimed that the unions are responsible for a major part of this development. What is significant is that the unions have a voice, in some instances the decisive voice, in the disposition of vast sums devoted to health coverage. How these funds are used may have an important effect upon the future organization of medical practice.

Perhaps a million workers and some of their dependents are covered by plans negotiated by the United Steel Workers; there is a similar number in plans in which the UAW has an effective interest. Last year the United Mine Workers fund spent $60 million in welfare funds. Even one local union in St. Louis, for example, representing employees in the lower wage brackets, has fostered a health program which presently has an annual budget of $1 million to provide comprehensive health care for 6,000 workers and about 8,000 dependents.[6]

Funds now are available to create well-equipped group-health clinics, if the unions decide that such is the better way to provide medical care.

In 1930 there was one consumer-sponsored health plan in the United States. Today there are scores of them, serving possibly more than 4 million people. The Health Insurance Plan of New York offers nearly comprehensive medical care to half a million people. The Kaiser Foundation with its ten hospitals, 25 clinics and 500 doctors offers similar care to about an equal number. The International Ladies Garment Workers' Union has health clinics in 14 cities offering preventive and diagnostic services and in some cases medical care to ambulatory patients. These centers are now available to 95 per cent of the union's 430,000 members. The AFL Medical Service Plan in Philadelphia services 33,000 union members and 22,000 dependents and has recently opened a clinic which will accommodate a population of 75,000. Other consumer-sponsored groups rely upon unions for much of the membership.

These are mentioned only as examples of the recent growth of consumer-sponsored health plans. In all, they represent but a small part of the vast program of prepaid medical care. They are significant when we realize that most of the growth of this type of plan has occurred since 1948.

Unions want preventive care. They want complete coverage. A typical insurance plan provides neither. Data presented in *Medical Economics* last year suggest that the patient among the 120 million Americans who carries some form of voluntary health insurance will pay about 10 per cent of his hospital bill and that one out of six will pay as much as 40 per cent; on average about 20 per cent of surgical expenses must be met by the patient, with one out of three paying as high as 40 per cent and one out of six as much as 60 per cent. Data on maternity cases are spotty but it is estimated that one out of three patients pay 20 per cent of the total medical expense. The typical patient paying as much as 40 per cent

Complaint of Fees

The most insistent complaint of administrators of union funds, however, relates to the size of the doctors' and surgeons' fees. There is a widespread feeling among such administrators that doctors, in judging patients' ability to pay, add to the insurance allowance approximately what they would have charged the patient had he not been insured. These officials have the impression that the doctors think that the insurance is not a cost to the patient but rather a donation from his employer and that the burden of carrying such insurance does not affect the patient's financial status. Such a judgment, the unions are quick to point out, is unsound. The employer's "contribution" to health and welfare has usually been won by the union at the cost of wage increases which were sacrificed.

The threat of the United Steel Workers to take its million members out of the Blue Shield program may be taken as an index of labor's feelings in these matters.

Mr. Walter Reuther's position is significant, not merely because he is head of the United Automobile Workers and of the Industrial Union Department of AFL-CIO, but because it reflects the thinking of a very large number of labor leaders. Reuther has been quoted as saying that the worker

[5] U. S. Department of Labor, Bureau of Labor Statistics, *Wages and Related Benefits 40 Labor Markets 1951-52* (Bulletin No. 1113). Washington, U.S. Government Printing Office, 1952, p. 57.

[6] See A. H. Scheller, S.J., "How Co-op Health Plans Work," SOCIAL ORDER, 3 (October, 1953) pp. 357-61.

[7] "Health Insurance Goal," *Medical Economics*, April, 1957, p. 90.

wants to know why, after paying his insurance premium, he has to pay out substantial amounts to the doctor when he has an operation; why he may have X-ray tests "only" when hospitalized; why so many medical services are not covered by insurance. The UAW president states that there is no longer a question about whether the worker is to have an adequate prepayment plan, but only how he is to get it. Reuther asserts:

> We cannot accept that quality is automatically lowered by any change at all in the prevailing pattern of practicing medicine and paying for it. . . . Unions will experiment with broadened prepayment and medical care organization.[8]

Speculating on these and other recent developments, Wallace Croatman last October raised the question, "Is Labor Through with Private Medicine?"[9] Nelson H. Cruikshank, the Director of the Department of Social Security, AFL-CIO, was quick to reply with an emphatic "no" in the same journal the following month. He added, however,

> . . . trade unions should be free to choose the type of program that best fits their needs, means and desires. We also believe that group-practice and direct-service programs should be among the choices available to them. Some [unions] prefer one plan; some prefer another. And they undoubtedly always will.[10]

It would appear that labor is determined not to sponsor in any wholesale fashion prepaid, direct-service medicine but to establish the right to experiment with such forms of medical organization. In taking this position unions came into head-on conflict with what appears to be the inalterable opposition of organized medicine. What is likely to be the outcome of such a conflict?

This is a question which needs to be seriously considered before any answer is attempted. There is a genuine possibility that if a conflict develops the medical profession may win the early engagements, with all of us, the medical profession and unions included, losing the war.

The sincere conviction of organized medicine in the soundness of its position and its undoubted strength in holding that position may blind it to the much larger risks involved. Skilled as doctors are in the arts of their profession they, as a group, show little adroitness in taking the public pulse.

The effectiveness of sanctions within the reach of organized medicine is best realized by members of the profession itself. A union-sponsored clinic, if it is to operate, must get doctors and the doctors must have hospital facilities. The medical director of such a clinic, a surgeon of considerable reputation, has told me of his experience in recruiting personnel. He has what he considers an adequate medical staff but he has not always been able to get the men he wanted. The young specialist who has passed his boards tells him frankly that he would welcome the opportunity of part-time assignment to the clinic, its assured income and the immediate prospect of practicing his specialty; he also tells him with equal frankness that he "can't take the chance." If he did, he would not get referrals; he would endanger his hospital connections. He must, he explains, think not only of the next three but of the next 10 years. The possibility of expulsion from a county medical society is a powerful deterrent.

[8] "Reuther States His Case," *Medical Economics, November,* 1957, p. 173.
[9] *Medical Economics,* October, 1957, p. 174.
[10] *Medical Economics,* November, 1957, p. 48.

Struggle in Prospect

Organized medicine should recognize, however, that in a contest with unions it would meet an antagonist experienced in conflict, one with resources to carry contests to the courts, an adversary not devoid of influence with the public and with national legislatures.

The contest which is now going on between the director of the United Mine Workers Memorial Fund and some representatives of organized medicine might well suggest that unions will not easily relinquish a position which they feel compelled to take in the interests of their members. Another issue is involved in that controversy. Although originally permitting its beneficiaries to select any doctor of their choice, about a year ago the Fund removed some doctors and hospitals from its panel. Medical societies in Pennsylvania, Illinois and Colorado reacted promptly.

The Fund's version of the controversy is stated in an interview with Dr. Warren F. Draper, its medical director, early this year.[11]

"We want," says Dr. Draper,

> to use the men best qualified to provide the care that our individual patients need. But organized medicine is taking a stand for free choice without a clear definition of the phrase. . . . The medical societies . . . are putting up a hard fight against our right to be selective.

He goes on to say that the medical plan was originally set up on a fee-for-service basis but that the Fund found that it was "tending toward subsidizing a gravy train." "In many communities," Dr. Draper continued,

> the surgical diagnosis and the operative surgery for Fund beneficiaries were clearly inferior in quality. And the amount of surgery performed was far in excess of what is performed on the general population.

Since unrestrained free choice did not work, the Fund wanted a system that would. It tried, said Dr. Draper, various plans. It tried to negotiate with medical societies in Pennsylvania without success.

When asked how the Fund would meet the opposition of medical societies, the UMW Fund's director replied that they were meeting it. In the Pittsburgh area the Fund dropped 200 doctors and 11 hospitals from their plan but have left 850 doctors and 17 hospitals for the members to choose from. Dr. Draper added that the vast majority of physicians who have worked with the Fund are satisfied with it. It may well be signficant that some county medical societies in Illinois quietly tabled the resolution of the State Medical Society about cooperation with the Fund. When we remember that the Fund spent about $60 million last year on medical care, we can anticipate that doctors, especially in com-

[11] Louis R. Chevalier, "Free Choice Has Failed," *Medical Economics,* January, 1958, p. 72.

munities where the Fund is an important source of much of the money spent for medical care, will not present a united front in any campaign which organized medicine directs against the Fund.

In Las Animas County, Colorado, the local society has taken punitive action against two physicians who disregarded its resolution and continued to cooperate with the Fund. They, in turn, have filed a suit in Colorado courts. The outcome of this action will be carefully watched by organized medicine, by unions and by large sectors of the general public.

One of the major problems faced by lay organizations, such as labor unions, who are interested in service-type medicine is the extent to which they can participate in organizing and directing groups which provide medical service. Both statute law and court decisions in many states are unfavorable to lay intervention in medical care. This fact in the past has permitted organized medicine to boycott such lay-sponsored groups with considerable success. There is evidence, however, that the courts are looking with greater favor upon such plans and are, as a result, scrutinizing boycotts against them by the organized medical profession.

In 1937 some federal employees in the District of Columbia organized the Group Health Association, a nonprofit prepaid medical care and hospitalization program offering service to government employees who met certain qualifications. The Association hired physicians on a salary basis to provide medical care for members and their families. The District Medical Society opposed this lay-sponsored group and expelled or otherwise disciplined some doctors who cooperated with it. The threat of expulsion from the medical society induced other doctors to withdraw from the association. Since Group Health Association had no hospital of its own, its staff had to rely upon hospitals in the community. The American Medical Association and the District Medical Society succeeded in persuading most of the hospitals in the District to deny their facilities to the Group Health Association staff. These actions led to criminal prosecution by the Justice Department under the Sherman Anti-Trust Act and in 1941 both the District Medical Society and the American Medical Association were found guilty of criminal conspiracy and in 1943 the Supreme Court of the United States refused to review the conviction.[12]

While this case is undoubtedly important as an indication of the attitude of federal courts toward systematic boycotts of lay-sponsored health plans, its value as precedent can easily be overestimated. Because the action took place in the District of Columbia, it was unnecessary to show that interstate commerce was involved in order to invoke the jurisdiction of the federal courts. Within one of the States, when the Sherman Act is invoked in an action alleging boycott, it would be necessary to prove both that a conspiracy existed and that interstate commerce was affected. Medical practice by its nature is essentially intrastate and conspiracy is always difficult to establish. It is doubtful, therefore, that the Sherman Anti-Trust Act will play any large future role in medical cases.

Some of the state courts, however, have shown an indication to adopt attitudes similar to that shown by the federal courts in the Group Health Association case. In the contest between the Group Health Co-operative of Puget Sound and the King Company Medical Society, the Supreme Court of Washington stated:[13]

> . . . The [medical] society, in characterizing appellants' contract practice as "unethical," is making an unusual and arbitrary application of that opprobious term. It is not using the term as a label for conduct which is violative of some established moral principle applicable to the medical profession. Rather it here uses the term to castigate those who seek only to carry on contract practice independent of and in competition with Service Corporation. In our opinion, the Society may not, through the mere use of the term "unethical," clothe with immunity acts which would otherwise fall under the antimonopoly provisions of our constitution.

More recently, in 1952, in a case involving a county medical society and a local health plan, a California trial judge found that the prepaid program was not engaging in the illegal practice of medicine but, rather, was bringing patient and doctor together under an arrangement which offered medical care at reduced cost. The judge expressed the opinion that voluntary health plans are part of our times and may be "the answer to socialized medicine." "Some believe," he said, "that if we stop them we shall have to take the alternative, a system of state medicine financed through taxes."[14]

In 1955 the opinion of the attorney general of Minnesota was asked about the legality of chartering a nonprofit group to provide comprehensive, prepaid medical care. He distinguished two previous cases in his state which had held such groups illegal on the ground that these decisions dealt with profit-making associations. After examining decisions in related cases in other jurisdictions, he concluded that the consumer plan was concerned not with the professional but only with the economic aspects of medical practice.[15]

[12] *United States v. American Medical Association*, [130 F.2d 703 (D.C. Cir.), cert. denied, 310 U.S. 644 (1940)]. See also: *American Medical Association v. United States* [317 U.S. 519 (1943)].

[13] *Group Health Cooperative of Puget Sound v. King County Medical Society*, [39 Wash. 2d 586, 603, 237 P.2d 737, 747 (1951)].

[14] *Complete Service Bureau v. San Diego County Med. Society*, [43 Cal. 2d 201, 272 P.2d 497 (1954)].

[15] "The objectionable features of the 'corporate practice of medicine,' or of any other profession, as stated by the Minnesota Supreme Court in the cases cited above, and by the numerous other courts that have considered the problem, are that the exploitation of the profession leads to abuses and that the employment of the doctor by a business corporation interposes a middleman between the doctor and the patient and interferes with the professional responsibility of the doctor to the patient. The corporation considered here would be non-profit and has a provision in its articles of incorporation prohibiting the corporation from intervening in the professional relationship between the doctors and the member-patients and confining the corporate activities to the economic aspects of medical and dental care. Therefore, a corporation so organized would not be subject to the objections urged against the business corporations that have been held prohibited from entering this field." (Unpublished opinion, Oct. 5, 1955.)

Despite what appears to be a more favorable trend in judicial opinion to the lay-sponsored health plans, the fact remains that union and consumer groups still find that the law is a major obstacle to the organization of prepaid medical care plans. In varying degrees statutes in many states restrict the operation of such plans to those with medical society approval or control. Some statutes require that a majority of the directors be doctors, others provide for medical society approval of directors, others bar a prepayment plan unless it includes the majority of the licensed physicians in an area. Such statutes are almost insurmountable hurdles for lay sponsors who want to organize a prepaid comprehensive plan.[16]

The American people, however, is determined that all its constituent groups shall have health care at a cost they can afford. There is a growing conviction that prepaid service-type medicine will afford that care at a cost within their reach. If experimentation with such plans becomes a matter of public controversy, an aroused public opinion, stimulated by organized groups including but not confined to labor unions, may lead to legislation at the national level which would modify the structure of medical practice in even more drastic ways. If, however, experimentation is permitted, the verdict on prepaid, comprehensive-type medical service will be rendered by experience; the deciding factors, moreover, will be the quality of care, the satisfaction of patient and doctor and relative cost.

Is consumer-type medicine inferior? A study of the Labor Health Institute of St. Louis, Missouri, made in 1954 by Dr. Franz Goldman, M.D., Associate Professor Medical Care, Harvard University School of Public Health, and Evarts A. Graham, M.D., Bixby Professor of Surgery Emeritus, Washington University, St. Louis, Chairman of the Board of Regents, American College of Surgeons, said:

> In volume and direction the medical service, diagnostic tests, and hospital services received by the group met high standards. . . . The record . . . is all the more impressive as the group eligible for service consists of individuals and families earning less than $3,000 a year in the great majority of all cases. As apparent experience shows, people in this income-group usually obtain only a fraction of those services which the L.H.I. provides routinely.

In its summary the report quotes a comment made by one of the physicians of the regular staff. "I wish I could practice as good medicine in my own office as I can here."

Regarding the compensation of physicians, the report stated:

> . . . An internist who serves 12 hours a week at the medical center, makes the necessary visits to hospitalized patients, and takes care of home calls can count on an annual net income of at least $6,700. A pediatrician who has a schedule of 5½ hours of service a week at the medical center, visits children, mainly newborn, in the hospital and answers home calls earns approximately $5,300 net per year. A surgeon who spends six hours a week on service to patients at the medical center, performs an average of eighty operations in the hospital during a year, and discharges administrative functions at L.H.I. has a net income of approximately $7,200 per year.
>
> It is hard to imagine criticism of these net incomes on the grounds of inadequacy or unfairness.[17]

Experience of the H.I.P. in New York and to a lesser degree with L.H.I. in St. Louis has revealed some dissatisfaction on the part of patients. The experience of both plans, it should be remembered, has been comparatively brief. The evidence of the Goldman-Graham reports suggests that these plans may render a quality of service which recipients in the lower-income groups could otherwise not afford; further experimentation might evolve arrangements which will eliminate the basis for most dissatisfaction on the part of patients.

A very fundamental issue is the cost of such plans. These programs are not cheap medicine. They were launched during a period of prosperity unequaled in our history. The budget of the L.H.I., for example, is more than $1 million a year. It has yet to be demonstrated that year-in-and-year-out, in good times and bad, a low-income group of 6,000 workers can afford such an outlay. These basic issues must be settled by experience and experimentation.

Costs rising

Public interest in the cost of medical care will become more alert in the future because the cost of such care is rapidly mounting. Associated Hospital Service of New York, which administers the Blue Cross Plan in the New York metropolitan area, recently presented a public hearing for a 40 per cent increase in its rates.[18] Insurance companies handling group hospital insurance have been increasing their premiums. Mr. Walter M. Foody, Assistant Vice-President of the Continental Casualty Company of Chicago, was quoted last fall as saying:[19]

> Many of our group policies, maybe half of them, have gone up an average of five per cent a year over the past two years. Some increased as much as 20 to 30 per cent.

This increase in hospital rates reflects in part greater utilization of the hospitals by doctors and patients. It reflects also the fact that many of the programs pay sickness benefits only when the patient is hospitalized, thus assuring increased use of hospitals during sickness. But a major part of the increased premium reflects the rapidly mounting costs of labor and equipment in the hospitals. Nonprofit hospitals in 1946 reported an average cost of $10.04 per day. By 1956 the cost more than doubled and is expected to go higher. More frequent use of expensive drugs and equipment adds further to the cost. Doctor bills, too, will probably increase on average. It is unreasonable to expect that physicians will be satisfied with static incomes in a period of inflationary trends.

Other very real problems of medical care will get increasing attention from the public. People are living longer and the older

[16] See "The American Medical Association: Power, Purpose, and the Policies in Organized Medicine," *Yale Law Review*, 63 (May, 1954) p. 993.

[17] These data on physician income relate to 1954. The writer has been informed by one of the participating physicians that the amounts should be increased by approximately $1000 each to make them current.

[18] *Wall Street Journal*, November 22, 1957.

[19] *Ibid.*

they get the more pressing become their medical needs; yet few of these older people are in position to pay large hospital and medical bills. Many people in these age groups are not insurable, or insurable only at very high rates. All of these problems will increase pressure for federal interest and federal aid in medical care.

Rapidly changing medical techniques, rising costs of medical care and the increasing demand that more medical care be made available to all segments of the public will undoubtedly promote further experimentation with forms of medical practice. The real threat to the physicians' independence is not prepaid service-type medicine. Rather, it is that private groups which are currently sponsoring such programs may yield to the temptation of thrusting the burden on government. To the layman the questions involved in such programs are essentially issues not of medical ethics, but of medical economics. Only by meeting these questions in terms of the real issues can organized medicine contribute to their solution. By assuming leadership in experiments with new and unproved systems of practice and payment organized medicine can best insure preservation of the profession's essential interests and independence

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