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Providing Adequate Medical Care —A Response to the AMA

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Accompanying a recent bar association publication, the members of the bar received propaganda material issued in the name of the American Medical Association, including a booklet entitled "Compulsory Health Insurance versus Health—the American Way." Assurance was given that the "other side" would be presented in DICTA at a later date. A full presentation of the "other side" would fill several DICTAS. There is here presented as much of the "other side" as reasonable space limits permit.

The AMA material referred to was prepared by Whitaker & Baxter, San Francisco publicity agents, as a part of their work for what is said to be the largest "public relations" fee on record—paid from the $3,500,000 fund raised by a $25-per-member assessment for fighting proposed compulsory health insurance.

On February 11, 1949, Dr. Edwards A. Park and 167 other distinguished physicians issued a statement roundly scoring AMA leadership for failing to "come forward with a comprehensive, constructive plan to extend and improve medical care" and refusing to pay the assessment if it were to be used for "propoganda and lobbying". Two days later the AMA published a 12-point program "for the advancement of medicine and public health". Examination of the 12 points makes obvious its hasty preparation in an effort to meet the telling criticism of Dr. Park and associates. Although hastily prepared, incomplete and ill-considered, it remains the only alternative to compulsory health insurance proposed by the AMA to meet the nation-wide need for more and better health education and medical and hospital care. That need is a matter of common knowledge and is impliedly admitted by the AMA itself in its proposal of a program allegedly designed to meet that need.

Let us, therefore, briefly consider the AMA 12-point program, the legislation pending in Congress and the British "National Health Service" program (still in its early trial stage).

A sketch of AMA's past attitude toward plans to meet the nation's need for better health and medical service will help in understanding and evaluating the 12-point program and in arriving at some conclusion regarding its real objectives and its results, if put into practice.

In 1932 the AMA Journal blasted voluntary health plans as "socialism, communism—inciting to revolution" and rejected the majority report of the Committee on the Costs of Medical Care (headed by Dr. Ray Lyman Wilbur, former AMA president and Secretary of Interior under President Hoover) recommending prepaid insurance and group practice.

When Blue Cross began in 1933, the Journal branded it as a "half-baked scheme" and sniped at the American College of Surgeons, who approved the

Blue Cross plan in 1934. Even as late as 1940 the Wisconsin State Medical Society forbade local units cooperating with Blue Cross.

AMA's Record vs. Voluntary Health Groups

The AMA's opposition to group health insurance followed "the American Way" to such a point that in 1938 the Department of Justice brought a criminal suit under the Sherman Anti-Trust Act against AMA and the District of Columbia Medical Society. Evidence revealed that employees of Home Owners Loan Corporation had organized a comprehensive cooperative health program called Group Health Association; that the District Society after having failed in a court attack on the Group, had tried to destroy the plan by refusing admission of Group doctors to practice and barring Group patients from Washington hospitals. The District Court convicted and fined the Society and the Association, *U. S. v. American Medical Association et al.*, 130 F. 2d 233. Upon appeal the District Court was affirmed in the Circuit Court of Appeals of the District and the Supreme Court refused certiorari. The Circuit Court of Appeals commented:

> ". . . Profound changes in social and economic conditions have forced members of all professional groups to make readjustments. The fact that these changes may result even in depriving professional people of opportunities formerly open to them does not justify or excuse their use of criminal methods to prevent changes or to destroy new institutions. Lawyers, too, have seen during recent decades, large scale changes in their professional work. . . .
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> "Professions exist because the people believe they will be better served by licensing especially prepared experts to minister to their needs. The licensed monopolies which professions enjoy, constitute in themselves severe restraints upon competition. But they are restraints which depend upon capacity and training, not special privilege. Neither do they justify concerted criminal action to prevent the people from developing new methods of serving their needs. There is sufficient historical evidence of professional inadequacy to justify occasional popular protests. . . . The people give the privilege of professional monopoly and the people may take it away."

Finding direct opposition to insurance schemes untenable, AMA and professional medical societies in the various states belatedly organized insurance plans completely under their own control. They entered the political field and lobbied for laws restricting to the medical profession alone the right to organize and administer insurance plans. The success of their efforts is indicated by the fact that today 22 states have laws granting virtual monopolies to state medical organizations in the field of health insurance. Such laws add irony to Whitaker & Baxter's cliche-ridden pamphlets bearing the slogan "Keep politics out of medicine". They carefully omitted the warning "Keep medicine out of politics".

The AMA 12-Point Program

With this background in mind, let us consider the first allegedly constructive proposal that has eminated from the AMA—namely the "12-point program", which is, in substance, as follows:

1. Creation of a federal department of health of cabinet status, headed by a doctor of medicine.
2. Promotion of medical research through a national science foundation.
3. Aid through the states to the indigent and medically indigent by utilizing and expanding voluntary hospital and medical care plans.
4. Establishment in each state of a medical care authority to handle funds.
5. Development of diagnostic facilities, health center and hospital services.
6. Establishment of local public health units.
7. Aid to mental hygiene clinics.
8. Health education programs administered through state agencies.
9. Provisions of facilities for care of the aged and chronically diseased.
10. Integration of veterans' medical care with other medical care programs.
11. Greater emphasis on programs of industrial medicine.
12. Adequate support with funds for medical, dental and nursing schools.

All of these proposals involve Federal financial aid.

One of the most telling appraisals of the AMA program comes from a member of the profession, Dr. Channing Frothingham of Boston, twice president of the Massachusetts Medical Society:

> "AMA's first proposal—for creation of a federal Department of Health with cabinet status—was rejected by the 80th Congress and was more recently turned down by the Hoover Commission and the House Expenditures Committee. . . . The proposal for putting a doctor in the cabinet is as out of step with American tradition as for the Army to demand a general in the cabinet. . . .
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> "Some of AMA's 12 points are mere pious platitudes calling for expansion of present government activities such as health education and industrial medicine (Nos. 8 and 11). Some already are incorporated in law—such as government aid for construction of hospitals (No. 5) and a program for mental hygiene (No. 7). Others are included in legislation now pending before Congress—such as creation of a national science foundation (No. 2); state medical care authorities (No. 4); aid for local public health services (No. 6); and expansion of medical, dental and nursing education (No. 12). The AMA has initiated none of these advances. The AMA is merely accepting the inevitable and belatedly jumping onto the band-wagon as it has in the case of most social advances in the past.
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> "The AMA's only proposal for meeting the national problem is

the same as before—voluntary health insurance. It has not moved an inch on this basic issue, despite all the window dressing.

"Voluntary health insurance has proved it cannot meet the nation's needs. Despite the AMA's frantic effort to promote such programs in order to head off compulsory insurance, the voluntary medical insurance plans favored by the AMA cover less than a sixth of the population and offer only limited protection. They are either wholly controlled by the AMA's state and local medical societies or are merely cash benefits paying a fraction of medical costs through insurance companies. . . .

"The AMA proposes that government funds, provided by the taxpayers, be used to aid these private programs so that they can take in the 'indigent and medically indigent' persons. The AMA's own statistics show that 80 percent of the population—all of those with incomes under $5,000 a year, are not able to meet the expenses of serious illness out of their own resources. The AMA's so-called program means that millions of self-respecting American families would have to be labelled as 'medically indigent', after an investigation of their personal finances, before they could get the government aid the AMA proposes.

"The AMA has fought national health insurance, the cost of which would be borne by the beneficiaries and their employers, as too expensive. It has made no estimate of the cost of its own point nine, or its proposal to subsidize AMA-controlled voluntary insurance plans. We challenge the American Medical Association to make such estimates. They might disclose that organized medicine is more concerned over who controls the finances of medical care than how much it costs the people."

The Truman Health Plan in Contrast

Disapproval of the AMA's aggregation of generalities called a "program" does not mean that we should adopt the so-called Truman Health Plan, as incorporated in proposed and pending legislation, in its present form.

Three bills are pending in the Senate, all introduced in the first session of the 81st Congress. Seven were introduced and are pending in the House (HR 4918-4924 inclusive). Any detailed discussion of even one of these bills is precluded by space limitations. The titles of the three Senate bills indicate the objects (quite similar to the avowed objectives of the AMA "program" but without the "doctor control" features). These are S.5 "A Bill to provide a national health insurance and public health program"; S.1970 "A Bill to facilitate the broader distribution of health services, to increase the quantity and improve the quality of health services and facilities, and for other purposes"; and S.1679, "A Bill to provide a program of national health insurance and public health and to assist in increasing the number of adequately trained professional and health personnel, and for other purposes".

The plan proposed in these bills is, substantially, a government operated form of group insurance, providing medical, surgical, dental and hospital

services to those who pay premiums, and their dependents, wage-earners being required to pay the premiums in the form of a withholding tax. However, if the insured shall not have earned certain minimums for specified periods he is not eligible for the benefits. Some provision is made for the destitute in form of charity. The plan amounts to a combination of ordinary (but government-operated) group health and medical insurance for some, and "alms giving" of such services to others but, altogether, providing for not more than 60% of the population, according to the estimates of its advocates, which figure it is hoped could be increased to 90%.

Objection is made to such a plan because of its enormous cost. This is not a valid objection for several reasons. First, its aggregate cost would probably be no more (very likely less) than the aggregate now paid directly, or through private insurance, for all health services. Most of such direct and insurance expenses would be eliminate by the proposed plan. There should be added to those expenses which would be eliminated by the new plan, the wages now lost, or unemployment compensation paid, on account of absences from work resulting from diseases preventable by the more comprehensive health services which could be rendered under the proposed plan. The expenses would be changed in form or transferred but not necessarily increased.

The establishment of a public school system was opposed because of its expense and, especially, it was said to be unjust to tax childless people for the education of the children of others. Such objections would now be laughed at because we have learned that an educated community is worth all it costs and that the resulting benefits, even to the childless, greatly outweigh the burden of their school tax. If this be true of schools and an educated community, how much more will it be true of adequate health service resulting in a healthy community. The good health of all individuals in the community is of immediate and even greater concern to all the community than is the education of all individuals.

Second, we appropriate billions annually for army, navy and air force. General Eisenhower recently stated, in Denver, that these are "sterile" organizations, doing nothing productive or constructive and are maintained simply to protect what we have. If we freely spend billions for protection, we should not hesitate to spend billions to make our country more worth protecting.

Out of the present Federal tax dollar more than seventy-five cents goes for wars past, present and future and only six cents for welfare work. A substantial change in these proportions could well be made.

The objection to the plan on the ground of expense seems unjustified.

The Objection on The Grounds of "Bureaucracy"

The plan is objected to because it would create another large and powerful administrative agency subject to all the criticisms aimed at bureaucracy

generally. This objection is invalid in part and valid in part. The plan would eliminate much duplication by coordinating and consolidating into one comprehensive organization a number of government agencies now working in the fields of public health and public welfare, separately and without any correlation. To this extent, at least, the objection is invalid. The principal validity of the objection lies in the fact that the plan is incomplete and not all-inclusive. Only defined groups or classes are subject to the withholding tax. Only certain defined groups or classes are entitled to the services. Only those individuals within the classes or groups whose wages for defined periods meet certain minimum requirements, are eligible for benefits. There is distinction between the insured and the destitute. Each of these limitations necessitates what may inelegantly be called "bureaucrats" to investigate and pass upon eligibility. This branch of the work would involve more red tape (forms to be filled out, filed, etc.), more controversy and probably result in more dissatisfaction and expense than any other branch of the agency in charge of the administration of the plan. This could all be eliminated by making the plan all-inclusive—free health service to all who need it, as we furnish free education to all without regard to wages earned, taxes paid or taxes withheld. The raising of social and political morale by elimination of the red tape and the most objectionable part of the "bureaucracy", plus the resulting facilitation of administration of the plan and a higher standard of national health would, of themselves, fully justify the added expense of the all-inclusive free health services. The money saving of administration expense would be a further and most substantial compensation. This phase of the subject will be again referred to in discussion of the British plan to which attention is now directed.

Britain has had nearly 40 years of experience with a limited health insurance plan similar in many respects to the President's proposal for the United States. It was inaugurated in 1911 and was limited to those in the wage bracket under $1680 per year (a total of about 22 million). The funds were inadequate and fees to participating physicians hardly more than nominal. These facts caused the plan to be stigmatized as "charity" (with all its objectionable connotations) and caused the physicians to neglect patients under the plan and give their better services to the higher paying private patients. The present predictions that service will be of poor quality under the present British plan are falsely based upon experience under the 1911 law.

The New British Plan Superior

Because of this long and unsatisfactory experience with the limited and restricted 1911 plan, the National Health Service Act (passed in 1946 and put into operation July 5, 1948) expanded the coverage to the whole population and made all services free regardless of earnings. The removal of restrictions and limitations both on kinds of service and recipients, transferred a large part of the administration expense, required by the old plan, to payment for health services rendered.

About one-sixth of the total expense of the new plan is provided by withholdings from wages and the balance by general taxation, the same as we provide funds for schools. Administration of funds is through local executive councils and hospital boards, thus insuring responsibility to local problems and local needs. Participating doctors are paid by a capitation fee for each patient plus extra fees for special services rendered. Today 95 percent of the population of Britain is served by the plan. Eighty-nine percent of the doctors and 92 percent of the dentists have now joined the national health service. The present plan has eliminated the expensive and bureaucratic procedure of dividing the population into "indigent and non-indigent groups", and has concentrated the energies of its administrative machinery and medical staff on the problem of providing the best possible medical care for all of the people.

The British plan has been in operation less than 15 months—less than a year when much of the opposition propaganda was published in this country. A program furnishing full health service to the entire population of England, Scotland and Wales (about 45,000,000 people) cannot be either approved or condemned on the basis of results of one year of operation.

In place of careful analysis of the principles involved and a calm survey of the net overall results, the critics pick out minor features for ridicule. Much stress is laid by the opposition on the furnishing of free wigs to the bald heads. The tremendous demand for eyeglasses is cited, but the critics evade the shameful fact that, before the inauguration of the present plan, thousands were struggling along without needed glasses or bought them at Woolworth's, or inherited them from relatives. That such a condition is being remedied is cause for rejoicing—not for condemnation of the remedy.

After a hurried trip to England, Dr. Fishbein (recently muzzled Editor of the AMA Journal) pointed to the long lines of waiting patients, the overloading of physicians and the inadequate health facilities as results of the new scheme. Obviously much of the apparent inadequacy of services is the left-over from decades of practice a la free enterprise. Dr. Fishbein's rather naive conclusion, that a comprehensive scheme for spreading the costs of medical care over the whole population inevitably results in inferior medical care, is not borne out by available facts. Nor is the conclusion fair after so short a period of operation. It will take years for the British to build adequate facilities and to train the necessary staff.

Dr. Fishbein and his Tory counterparts charge that there is much "malingering" and "abuse of privilege". It would be strange if there were not, but the charges are petty in view of the benefits which have been brought to those unable to read for lack of proper glasses; to those living in the miserable isolation of deafness because hearing aids were beyond their financial reach; and to the vast majority of people in Britain who had gone without proper dental treatment all of their adult lives. No reasonable man will maintain that the system will be totally free from abuse. The significant fact is that Britain is now more effectively meeting her medical needs. Of course

some time will be required to meet the flood of pent-up demand, and time will be required to weed out abuse and malingering, but unbiased reports do not prove that such is on the increase, or that making health services available to all of the people has measurably increased abuses over earlier years of private or charity practice. Dr. Stanford Cade, noted British specialist who recently addressed the American Cancer Society, when asked about the truth of stories that British doctors were overloaded with malingerers, replied that he had not seen anything of the kind, that when the average Britisher calls on the doctor, he really needs one.

Two facts stand out in the British situation. An administrative enterprise of such gigantic proportions went into operation without breakdown or major difficulty and success has been such that the Tories find it politically expedient to promise expansion of benefits under the plan. Space limitation precludes discussion of many features of the British plan which will require change in the light of fuller experience, but these two facts are strong, if not conclusive, evidence that the universal "free" health service principle is basically sound.

The provision of adequate medical services to all of the people according to need will have to be realized sooner or later as a matter of national necessity in the United States. The AMA twelve points, as shown by the foregoing discussion, would lead only from confusion to futility. The plan proposed by the President is a halting step in the right direction, but, as we have pointed out, it would be administratively awkward and would fall far short of the goal. Why not plan boldly and adequately now?

Dier Memorial Services

As chairman of the Fellowship Committee of the Denver Bar Association, Floyd W. Walpole paid tribute to the memory of the late John Q. Dier at memorial services held at Crown Hill Mausoleum on September 11. Mr. Dier, for many years a distinguished railroad attorney and member of the Denver and Colorado bar associations, retired from practice in 1946. He died at Languna Beach, Calif. on August 16, 1949.

Open Competitive Exam for Denver Postmaster

President Stanley H. Johnson of the Denver Bar Association has received a letter from the U. S. Civil Service Commission requesting that publicity be given the fact that an open competitive examination is being held for the Denver postmaster position.

The closing date for this unassembled examination is October 11, 1949. The Denver postmastership pays $9850 per year, and a similar position at Durango, for which an examination is also being held, pays $4750. The necessary forms and information as to qualifications required may be obtained at the post office.

Word has been received of the recent death of Loring W. Jordan of Grand Junction.