The Present and Future Organization of Medicine

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I

TODAY MEDICINE STANDS AT A CROSSROAD. NO ONE can fully grasp the content of medical science and medical art or foresee the path which the newer knowledge will follow more than a decade hence. No one can fully comprehend the present position of medical practice in society or anticipate the form it is destined to take. This much is clear: Every serious effort to contemplate the course of future developments must draw a clear distinction between the *content* of medicine and the *form* of medical practice. This distinction may be brought into sharp relief by a few simple illustrations.

A patient appears in a physician's office. How the doctor shall proceed to take the medical history, upon what signs and symptoms he shall make his diagnosis and what course of therapeusis he shall prescribe—these are part of the content of medicine and are wholly within the domain of the physician. A patient comes to a dentist. The examination, the diagnosis, the program of care and treatment, decisions as to the need for cleansing, extraction, prosthesis, or orthodontia, and the performance of the services—these are part of the content of dentistry and are within the province of the dentist.

For its own protection, society has for many centuries regulated the privilege of the individual to hold himself out as a physician. Both in olden times and in modern, society has established standards which must be met by those who would qualify as practitioners. The individuals who receive approval are then entrusted to choose the procedures which will best serve each patient in his time of medical need. Physicians and

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dentists have had, have, and undoubtedly will continue to have, the sole right and duty to decide *what* shall be practised. This, the content of medicine, belongs to the practitioner.

We find another picture when we inquire into the circumstances under which the physician practises and the nature of his economic relations to society or to the individual patient. Everywhere and always, the physician has been a product of his times and the conditions under which he has practised have invariably reflected the customs of the period. In primitive times, he was physician, priest, and magician; in classical times he was variously slave, craftsman, honored citizen, and body-physician at the court of prince, king, or emperor. In early Christian times, in the Middle Ages, during the Renaissance, in the imperial, and in the liberal periods, his roles have been many and varied.

Between 1850 and 1930, the industrial revolution changed the world at a pace which has almost defied understanding or analysis. Simultaneously, medicine made more progress and became more efficient than ever before in history. Medical art and medical practice grew beyond the competence of any individual; and medical specialization—though not new in the world—attained such a state of development as to constitute substantially a new phenomenon in the history of science.

The profound economic changes which came with industrialization (and urbanization) brought colossal forces to play upon medical practice. The number and variety of practitioners grew in a manner hitherto unknown. Tremendous competition developed. Through circumstances which no one planned and no one foresaw, a profession fell into a business world. In order to survive, medicine began to adapt itself to the world about it. The older order of so-called "private practice" was transformed into a system of competitive practice which no one consciously willed and which in an insidious way has interfered with the great social task which medicine is destined to perform. The practitioners of the healing arts were compelled to become businessmen and entrepreneurs.

Fifty years ago, the world began to seek an answer to the paradox which the industrial revolution presented to the practice of medicine. In 1883, in an effort to weaken the growing influence of the Social Democrats, the Iron Chancellor gave Germany sickness insurance. Fundamental changes came into the conditions of medical practice—first in Germany and later in the forty countries of the world which followed her lead in establishing compulsory or voluntary systems of furnishing medical care through insurance. Health and sickness insurance evolved

in the same period which saw the gestation of modern medicine. In the same year in which sickness insurance was being instituted in Germany (1882), Louis Pasteur published his first communication on rabies and Robert Koch read his classic paper on the etiology of tuberculosis. This coincidence is not cited to prove that insurance against medical costs was responsible for medical advance, but to challenge the converse: The history of medicine since 1882 does not lend itself readily to the argument that the international spread of sickness insurance *impeded* medical progress.

The conditions under which medicine is practised, the nature of the physician's relation to the society of his times, the manner in which he is remunerated—these and other characteristics of the *organization of medicine* have known many patterns. In all countries of the world and for many centuries, the form of medical practice has been determined by the structure and the customs of society. And this is true in the United States today. In the light of this unquestionable lesson from history, it is absurd for the editor of a leading American medical journal to express the view: ". . . the right to say how medicine shall be practised must remain with the medical profession." The medical profession has not now that "right" any more than they had it in centuries past when physicians were permitted to practise as licensed wanderers, or as the salaried "body-physicians" of kings or princes, or as university faculties. Society has never delegated such a "right" to the medical profession; and today it might be difficult to discover evidences that society contemplates an innovation in this regard.

If the expression quoted above were merely the casual blurb of a journalist, it would be deserving of no specific attention. But it warrants comment because it represents the opinion of a number of self-styled leaders of the medical profession. There are signs everywhere in the United States that profound change impends in the organization of medicine. If physicians, dentists, and other members of the medical professions, are to exert useful and constructive influence, if they are to serve wisely in guiding the practice of medicine to a form of organization more esteemed by society than is the present one, they must take cognizance of the forces which are at work. The medical practitioner must range himself with—and not against—these forces if he would influence the course of events. It is not difficult to imagine the grave consequences which might befall if society should seek a new organization of medicine and did not have the counsel of the medical professions. As surely as the

professions determine *what* they shall practice, society determines *how* they shall practice. The interest of lay people is centered not on what the physician shall practice, but upon how he shall be paid for his services.

II

There is a ferment at work in American medicine. There is a vast unrest; physicians, dentists, nurses, hospital administrators, pharmacists, and others are conscious of a national uncertainty in the future of medical organization. The order of the nineteen-twenties has been under critical fire. This was already clearly evident in 1927 when the Committee on the Costs of Medical Care first came into being. It was concern over the future which brought the Committee into existence as a voluntary organization dedicated to dispassionate investigation of the needs of the times. The economic depression has only intensified the need for action.

To visualize the issues at stake, it is necessary to study the research reports prepared by the staff of the Committee on the Costs of Medical Care. Though there were differences of opinion within the Committee concerning *recommendations*, the *facts* disclosed by the Committee's investigations were accepted by all factions. The data are now a year or two old. But in this, they err only in understating the need for certain obvious changes in the organization of medicine.[1]

Among some groups it has become almost a pastime to lay the blame for the burden of medical costs on the drugstore and the cultist. Others frequently imply that most of our troubles would be over if these expenditures were eliminated and other recognized wastes were curtailed. We should not fall into the habit of taking these delusions too seriously. The obvious savings which are possible would amount to three-quarters of a billion dollars a year, or 20 per cent of the total costs of medical care in a normal year. But to effect savings of these kinds would, in the best of circumstances, be a slow and difficult task. Spending habits are deeply rooted and ignorance is not easily overcome. Even granting that these savings were effected, the facts in the case point conclusively that the major problems of medical costs would still demand other solutions. For the major problems are:

a. The uncertain, uneven, and unbudgetable size of medical costs for the individual or the family.

b. The difficulty of knowing how, when, and where to secure good medical care.
c. The uncertain and inadequate remuneration of practitioners and institutions.

Neither professional nor lay groups will make real progress on issues in medical economics until they recognize that these are the real issues which face the public and the professions and that the three are interlocked, one with another. The professions and the public will be toiling at cross purposes until they realize that each has an equal and fundamental interest in medicine and that the interests of both must be safeguarded in any solution which may be proposed. In principle, it is obviously desirable that any plan designed to equalize costs should also discourage waste. Experience in many places has shown that it is possible to combine these two desirable objectives. Indeed, the success of an organization which equalizes costs depends, in greater or lesser measure, upon the fact that it simultaneously reduces wastes, familiarizes the beneficiaries with the path to authorized medical agencies, and stabilizes the incomes of practitioners. By comparison with what has been and is easily accomplished in the reduction of wastes through organized medical agencies operating under non-profit insurance plans, reduction in wastes by educational measures alone is costly and ineffective. Proposals to reduce costs and to eliminate wastes must inevitably be linked with proposals to equalize costs among groups of people and over periods of time. In any final sense, the economic and professional needs of modern medicine call for group payment by the public, group practice by the professions, and a conjunction of the two.

III

The public and the professions are convinced that on the whole "all's well" with the science and the art of medicine. No one knows its destination; but it is on its way and its way seems to be a highroad. But the serenity with which the *content* of medicine is viewed has no counterpart in the attitude toward the *form* of medical organization. On the contrary, it is a common belief that, in respect to organization and social relations, medicine is at a crossroad and has not yet found the signpost. The view is extremely prevalent in the public mind; it is almost

general among hospital and public health authorities, and it is—to put the matter conservatively—common among the members of the medical professions.

There are two distinct but interrelated questions before society and the professions: Toward what form of organization is medicine heading? How shall it be most wisely guided to a desirable form? Let us consider these in turn.

A vast experimentation is in progress in the United States and in foreign countries. Disregarding details, we can discern at least six major movements:

1. An increasing prevalence of group payment of medical costs. This is notably evident for hospital service and has become quite common for care furnished by physicians.
2. An expanding activity of government agencies in furnishing diagnostic and curative as well as preventive care.
3. An expanding interest of private practitioners in preventive medicine.
4. A growing tendency toward group—as distinguished from individual—practice.
5. An increasing demand for the effective control of excessive specialization in the professions.
6. A widening interest in the possibilities of improving the education of general practitioners and restoring them to a central place among their professional colleagues.

These and other important movements must somehow be fused into a single current. All must be encompassed in any sound program of medical organization for the future. In this country and abroad, many experiments have been (and are being) tried to attain these six objectives. A study of experience suggests that, whatever the near future holds, sound planning must rest upon the following basic principles:

1. The provision of good medical care to all of the population is essential to the nation's well-being.
2. The costs of medical care should be distributed over groups of people and over periods of time, whether through taxation, insurance, or combinations of the two.
3. Those who render medical care should be adequately remunerated.
4. Quality in medical care should not be sacrificed to economy in cost.

5. The medical care of the dependent and indigent sick is an obligation of society.
6. Group payment of medical costs should be restricted to this purpose and should not be combined with insurance against the loss of wages during a period of illness.
7. Group payment of medical costs should embrace all economic groups in the population to whom the private purchase of medical care brings variable costs which are burdensome and which are incapable of being budgeted on an individual or family basis.
8. The costs of medical care must be distributed according to ability to pay.
9. Group payment of medical costs should be grounded on a compulsory basis.
10. A system of group payment for medical care should not include or permit the operation of proprietary or profit-making agencies or of any independent intermediary between the potential patient and the medical agencies.

Whether we like them or not, an evaluation of European and American experiences reveals that these principles are sound. The form of organization to which medicine is moving should be conceived in these principles. In addition, experience shows that effective operation of a system of compulsory insurance against medical costs requires:

a. Flexibility in the scope of medical benefits so as to permit adaptation to local variations in available personnel and facilities.
b. Professional control of professional personnel and procedures.
c. Freedom of all competent practitioners who subscribe to necessary rules of procedure to engage in insurance practice.
d. Freedom of all persons to choose their physician or dentist from among all practitioners in the community who engage in insurance practice.
e. Freedom of insurance practitioners to accept or reject patients.
f. Minimum interference of the insurance system with the private practice of medicine.

On these premises, the immediate task is to design a form of organization which is in accord with these basic concepts and which will operate effectively.

IV

How shall we proceed to formulate a program for the place which medicine shall occupy in society? Can it be done by the medical professions alone? There are no evidences in medical writings that medical practitioners have either the training or experience in the social or economic problems which would qualify them to act *alone*. In addition, medical practitioners would be subject to popular suspicion in such an undertaking because they have a large stake in the outcome. Furthermore, the lay world has so profound an interest in the subject that one can anticipate a general revolt against anything which would seem to be dictation to society from the professions. There is an old adage which is pertinent: "He that reckons without his host must reckon again."

Can an adequate program be formulated by the public or by their leaders in government? The answer is written indelibly in history. Bismarck, single-handed, gave Germany sickness insurance; Lloyd-George and his small coterie gave Great Britain national health insurance. The place which medicine shall occupy in the social order has for centuries been determined by the lay world and this can be done again. Unfortunately, there is a very clear lesson in modern history that such action is not in the best interests of society. Success in the operation of any national plan for the organization of medicine has been almost directly proportional to the extent to which there has been professional, conjointly with lay, participation in designing the program. The history of health insurance in European countries is replete with illuminating examples on this point. The role which the British medical professions played in compelling a revision of Lloyd-George's program, before the National Health Bill was enacted and during the first years of its operation, is a case in point. Today, satisfaction with national health insurance is so general in Great Britain that no responsible group would propose its abolition. Both the public and the organized medical and dental professions are clamoring for extension of the system. The demand is for more, not for less, national health insurance. And this is especially evident in the official proposals of the British Medical Association.

If we learn anything from history, we must be resolved that the economic problems which confront American medicine should be solved by the joint action of lay and professional groups. Yet we must recognize that if such cooperative action does not become a reality, solutions

may be imposed upon both the public and the professions by ambitious politicians or by designing bureaucrats. And these solutions may not be the best which can be designed in the public interest.

Many persons, lay and professional, are convinced of the need and the opportunity for public service in a sound reordering of the functional relations of medicine. No good purpose is served by denying existence of the problem or by acrimony between lay and professional groups which have fundamentally common interests. Neither denials nor hard names will create a current or stem a tide. The times call for action and the problems for wise and judicious solutions.

Endnote

1. The factual information and its analysis are available in a single volume: Falk, I.S.; Rorem, C. Rufus; and Ring, M.D.: *The Costs of Medical Care: A Summary of Investigations on the Economic Aspects of the Prevention and Care of Illness*. Chicago, University of Chicago Press, 1933. A brief resumé (Fundamental Facts on the Costs of Medical Care, by I.S. Falk) appeared in the Milbank Memorial Fund *Quarterly Bulletin*, April 1933, xi, No. 2, pp. 130–153.