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

THE first comprehensive study of the costs and distribution of medical service in the United States, has been concluded by the Committee on the Costs of Medical Care in a final report which is arousing many expressions of conflicting opinions regarding the changes recommended. The Committee, headed by Dr. Ray Lyman Wilbur and consisting of forty-eight members representing points of view of the medical profession, economists, sociologists, business men, and laymen, has been at work for five years. The results represent an investment of one million dollars granted by foundations, one of the first supporters being the Milbank Memorial Fund which gave $255,000.

The final report of this Committee, published in December, 1932, by the University of Chicago Press under the title, "Medical Care for the American People," summarizes and interprets the findings of fact previously published in twenty-six separate reports, and presents final recommendations by a majority of the Committee and by minority groups.

How to provide satisfactory medical service at costs which can be met without undue hardship by all people except the indigent while providing fair remuneration for the medical profession was the fundamental problem the Committee five years ago set out to investigate. It found that, at present, 38 per cent of the people in this country receive no medical, dental, or eye care, although its final report does not estimate how many of them needed such care. The rest are served very unevenly, with uneven costs, and with some doctors receiving too little money for doing the same work that pays others well. Meanwhile, nearly half a billion dollars a year is expended for patent medicines and "quacks."

As a cure for these and other ills, the Committee in its majority report prescribes organization of medical service in community medical centers and in groups of doctors; more public health service; payment in the form of small but regular fees, the same for everybody, through voluntary insurance in communities or groups of persons,[1] or through taxation or both; raising standards and cutting out overlapping work in counties, towns, cities, and states through the watchful help of councils specially organized, and better professional education for doctors and nurses. The objections to the majority report and the counter-recommendations by different minority groups and dissenting statements of individual members of the Committee will be discussed in connection with the following more detailed summary.

THE FACTUAL FINDINGS

Whatever differences of opinion there may be, the Committee has assembled and analyzed a vast amount of information never before available in one place. A few of the outstanding facts will illustrate the scope of the Committee's work.

More than one million American citizens make their living in the broad field of medical care and protection of health. For their services and for medicines, the American people spend three and a half billion dollars a year. This, if collected as a head tax, would be about thirty dollars each for every man, woman, and child in the country. There are nearly 7,000 hospitals with nearly one million beds. Nearly three-fourths of all patient-days of service are rendered by governmental institutions.

Full credit is given the medical profession for the remarkable advance of medicine both as an art and a science. The

[1]Several members signing the majority report favored compulsory insurance for states, especially the industrial states.

report says: "Physicians and other men of science have displayed an unparalleled generosity in making available to their colleagues and thus to mankind the results of their research and inventive genius." In contrast to this, medicine as an economic activity has made less progress, and its "predominant economic institution—private individual practice —dates back to ancient times."

The facilities for medical care "are not distributed according to needs, but rather according to real or supposed ability of patients to pay for service." For example, in 1929, there was one physician to every 1,431 persons in South Carolina as against one to every 571 in California, and one to every 621 in New York State.

Sickness falls alike on the rich and the poor, the survey reveals, and yet nearly two million families in the United States, whose incomes are less than $1,200 a year, "receive no professional medical or dental attention of any kind, curative or preventive," and this "in spite of the large volume of free work done by hospitals, health departments, and individual practitioners, and in spite of the sliding scale of charges." However, even the well-to-do families receive less medical care than they should have, according to standards accepted by the Committee. Most Americans stay away from dentists. "Among the mass of the population, only 21 per cent of individuals secure any dental care during an average year."

Preventive medicine is still little used. In any one year, less than 7 per cent of the population has even a partial physical examination and less than 5 per cent is immunized against some disease. The Committee refers to a special survey for the White House Conference which showed that only 51 per cent of city children and only 37 per cent of rural children had health examinations prior to their sixth birth-

day, and that only 21 per cent of city children and only 7 per cent of rural children have been vaccinated by the time they are six.

"American communities have been pitifully backward in utilizing modern public health procedures," says the Committee. Of the $30 per capita spent for prevention and care of disease, only $1 has been used for federal, state, or local public health service. In cities of 100,000 population, where satisfactory service calls for $1.79 to $2.13 per capita, the current expenditure is only 65 to 80 cents, and in county and rural health work, for which experts recommend $2.50 per capita, the expenditure averages less than 35 cents.

Meanwhile, perhaps a billion dollars a year spent to preserve or regain health is wasted, according to the Committee, by expenditure on "patent medicines," healers, and on inferior services, and by inadequate use of hospitals and of time and equipment of practitioners.

Most of what has been summarized above, though it will astonish the average citizen if he stops to think about it, will not long stay in his mind. But what he never forgets is that he cannot predict, nor can his doctor, how much money he may have to spend next year, or the year after, for doctors', hospital, and dentists' bills. "On the present fee-for-service basis, it is impossible for 99 per cent of the families to set aside any reasonable sum of money with positive assurance that that sum will purchase all needed medical care." Of the total money income in the United States, 4 per cent is spent for medical care. But "if a family lays aside for medical costs 4 per cent of its annual income (say $110), it may spend only $10 or it may spend $1000."

In 1928, nearly thirteen million families in this country had incomes of less than $2,000 a year, while only two and a half million had incomes above $5,000. Per capita income in

1926 varied according to geographical location from an average of $369 in four southern states to an average of $1,309 in the Middle Atlantic States. Besides the great disparity between actual and average incomes for a large majority of families, there is perhaps a greater disparity between actual and average costs of medical service.

The pay for the medical profession is also very uneven. While the average net income for physicians in 1929 was $5,300, half of them received less than $3,800, and one-third received less than $2,500. One-sixth of the physicians, however, received net incomes of more than $10,000. The average income of the rural practitioners is less than one-half of the average for metropolitan physicians.

Forty per cent of gross income of private practitioners goes for overhead, which raises the cost to the patient without financial return to the doctor. Collections, in 1929, were 10 to 20 per cent less than the amounts charged. From 1929 to 1930, the depression reduced professional net incomes 17 per cent, on the average. In four southern states, the reduction was 50 per cent. Discussing the hospital situation, the Committee questions "whether the voluntary hospital system in America can survive" in the face of reduced incomes from private philanthropy and community funds and increased demand for free service.

The capital investment in land, buildings, equipment, and endowment of hospitals and clinics in America amounts to $3,500,000,000. Ninety per cent of this has been provided by government funds or philanthropy.

The total investment in medical and dental service is about $5,850,000,000, of which $3,550,000,000 has been made by the public without expectation of financial return, while $900,000,000 has been invested by physicians and dentists in their own equipment or private hospitals. "An increasing

proportion of medical service," notes the Committee, is by practitioners "who use a capital investment provided by the public for the benefit of the public." About four-fifths of all the physicians in this country are associated with hospitals and clinics.

Drugs and medicines are purchased by the American people to the amount of $715,000,000 a year, of which more than half, "most of which is money wasted," goes for "patent medicines." The costs of medicine to a family, however, are seldom large enough to be a serious item in its budget.

Confusing to the patient is the growing complexity of medicine. There are some twenty-five specialties recognized, and in some communities as many as 30 per cent of the physicians limit themselves to specialization and almost as many more tend toward specialization.

After its summary of the medical situation, above outlined, the Committee cites various authorities and the experience of organizations in America with the system of providing complete or nearly complete medical service for weekly or monthly fees, and concludes that the cost, excluding capital charges, least for urban areas, amounts to twenty to forty dollars per capita per annum.

PRINCIPAL RECOMMENDATIONS OF THE MAJORITY

As a basic consideration for the reorganization of medical services, the Committee stresses the preservation of a personal relation between patient and physician as an essential element in safeguarding the quality of medical practice, but holds that private business relations between physician and patient are not considered necessary. It declares that professionally the family physician should be restored to a position of responsibility and trust. It further advocates a shift of emphasis from cure to prevention, and points out that,

from the economic standpoint, increased prevention will be needed to counteract the larger total expenditures necessary for better care of the sick.

In five formal recommendations, which have been widely published in the daily press, the majority group of the Committee sets forth its program. The keystone of this is the development of one or more nonprofit "community medical centers" in every city of approximately 15,000 population. This would provide complete medical care except for the tuberculous and for mental and other cases of institutional type. Although there might be lay participation in the administrative and financial control of the center, the professional personnel would control the professional work. Remuneration would preferably be on a salary basis, although it might be on a capitation or fee basis, or by a proportional division of receipts.

Affiliated branches of medical centers would be organized for towns with populations of 2,500 to 15,000. For the villages and distinctly rural areas, there would be "medical stations" related to centers or branches. Traveling clinics would be provided for special diseases.

The group does not propose, however, that such centers, branches, and stations should completely displace all existing agencies, nor that individual private practice, particularly among the well-to-do, should be discontinued.

MINORITY DISSENTS AND RECOMMENDATIONS

This proposed organization of medical services is vigorously opposed in a minority report, signed by eight physicians and one layman. This minority declares that the medical center plan "would establish a medical hierarchy in every community to dictate who might practice medicine there." The minority further declares that "it would be impossible

to prevent competition among the many such centers necessary for large cities; cost would inevitably be increased by the organization necessary to assign patients to the various centers," and that "continuous personal relationship of physician and patient would be difficult if not impossible under such conditions."

The clash, in brief, is between those who favor the continuation of the private physician as the unit and those who favor groups of various forms as units of organization. Even private pay clinics are not welcomed by the signers of this minority report. They accuse the majority, which includes seventeen doctors of medicine and one doctor of public health, of being too favorable to such groups. The minority argues that there is no proof that group clinics reduce costs, except by limiting service, as, for instance, by excluding domiciliary service. It holds that in large cities these groups lead to duplication of equipment, and, moreover, engage in competition, thus commercializing and lowering the standards of medicine. It states that "for the 85 per cent of illnesses which make up the family doctor's practice better service can be given by the individual doctor in his own office than in a clinic and at less cost." However, it approves "the development of pay clinics when they are under the management and control of physicians and are conducted on a high ethical plane and are needed to meet a situation."

A second minority report was submitted by two doctors of dental surgery, the only ones on the Committee. These two, while opposing the majority views on insurance, are in favor of group practice.

On the question of sickness insurance, the clash of opinion is even sharper. The formal recommendation of the majority group reads as follows:

"The Committee recommends that the costs of medical

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

Although the formal recommendation does not qualify the word "insurance" it is made clear in the discussion that voluntary nonprofit systems are meant, systems which would organize "industrial, fraternal, educational, or other reasonably cohesive groups." Eight members of the majority group dissent on this point and demand state-wide compulsory insurance in industrial states for certain income levels, certain occupations, or certain areas. They argue that voluntary insurance will never cover those who most need its protection, and that it will be more complex, more difficult to administer, and, in the long run, less economical than compulsory insurance. Professor Walton H. Hamilton, one of the two members of the Committee submitting individual statements, declares that compulsory insurance is the very minimum which the Committee should have recommended.

The nine signers of Minority Report Number One oppose voluntary sickness insurance not under control of the medical profession, declaring that where such systems have already been tried in America they are "giving rise to all the evils inherent in contract practice." They argue that if we must adopt insurance, the sensible and logical plan would be to adopt compulsory insurance under government control. They point out that in Europe voluntary insurance has usually led to compulsory insurance, but they add that the objections to the latter system are almost as compelling as are those to the former. However, in the further discussion, they say

that they are "not opposed to insurance but only to the abuses and evils that have practically always accompanied insurance medicine." They suggest that a form of sickness insurance based on experiments already tried by county medical societies may be the solution of the problem. The two signers of Minority Report Number Two strongly endorse this view.

Majority recommendations on which there were few if any differences in the Committee, call for the extension of all basic public health service; formation of agencies to evaluate and coordinate medical services; and broader and more complete professional education and training.

In a statement appended to the report, Edgar Sydenstricker says: "As a member of the Committee, I regret that I cannot see my way clear to sign the final report of the Committee for the reason that the recommendations do not, in my opinion, deal adequately with the fundamental economic question which the Committee was primarily formed to study and consider."

General comment on the report indicates appreciation of the value and importance of the work accomplished by the Committee on the Costs of Medical Care. A sound basis has been laid for further consideration of the way to provide adequate medical service for all the people with adequate pay for all the doctors.