

The Nation Archives

THE HEALTHCARE DEBATE

NO. 3. THURSDAY, ...

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...This week commenced the publication of a series of letters ...
...which will constitute at least an honest attempt to ...
...present regard to the possible effects of what we ...
...position of our political party. The public ...
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JOSEPH H. RICHARDS, PUBLISHER, 130 NASSAU STREET, N. Y.

The Week

THE NATION DIGITAL ARCHIVE
AN ALTERNATIVE HISTORY... SINCE 1865

INTRODUCTION

When *The Nation* first opened its pages to a debate on national healthcare, Calvin Coolidge was President of the United States. The year was 1928. Whole empires have come and gone since then, but despite the passage of seventy-eight years, the basic problem of how our country should care for its citizens still awaits resolution.

That the healthcare system in this country needs to be addressed, there can be no doubt. Dr. Marcia Angell of the Physicians For a National Health Program recently pointed out that Americans pay more for healthcare than do citizens of any country in the world. In fact, she says, we pay twice as much per person as those in other developed nations pay. And it's not that we get better care, either. "By the usual measures of health (life expectancy, infant mortality, immunization rates), we do worse than most other developed countries," she adds. "Furthermore, we are the only developed nation that does not provide comprehensive healthcare to all its citizens. Some 42 million Americans are uninsured — disproportionately the sick, the poor and minorities — and most of the rest of us are underinsured."

Why is this the case? As the articles you read make clear, opposition to a national healthcare program has been organized and powerful ever since the first voices were raised on its behalf. Opponents, led by the American Medical Association, have fiercely fought single-payer plans on many fronts, most importantly in Congress and the media. (The term "socialized medicine," which was applied to any proposed change to the healthcare system, was really a euphemism for communism.) When with great fanfare the Clinton Administration, spearheaded by Hillary Clinton, suggested modest alterations to the system, her proposals were beaten back so badly that more than ten years later politicians are still afraid to propose major changes, lest they suffer the same hostility from constituents fed with misleading information by those representing the entrenched industry or right-wing interests.

Can a national healthcare system work? We must look at other nations for clues. Great Britain, Canada, Russia, Cuba are just a few of the countries that have instituted different forms of national healthcare. Have they served their citizens well? Could their systems be adapted to work in the United States? Will they be? A lot has changed in the United States since 1928, and perhaps one day the healthcare system might join the list.

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April 25, 1928:

Socialized Medicine

By MORRIS FISHBEIN

THE modern science of medicine began with the discovery of bacteria by Pasteur about fifty years ago. Long before that time, however, Hippocrates had taught the art of observation and had called attention to the importance of the individual relationship of the physician to his patient. The most ancient of physicians recognized the fact that some persons could inspire the patient with a desire to recover and could apparently aid that peculiar power lying within the body known as the *vis medicatrix* nature, the power within living tissue that urges it to repair.

As time has passed, facts and methods have accumulated. The old-time physician who graduated from a two years' course of lectures, the same lecture being repeated during the six months of each, practiced a sort of "hit-or-miss" method of healing. He took the history of the patient, looked at the tongue, thumped the chest and listened to such murmurs as were easily apparent. On the basis of the general knowledge of the course of disease, he made a diagnosis. The practice of modern medicine is a far more complicated matter. It involves not only all of the things that have been mentioned, but also the use of much intricate apparatus, laboratory service, the X-ray; indeed, a study of all the secretions and excretions of the human body.

As a result, the cost of medical care has increased greatly and is giving concern to sociologists and economists. For some time the statement has been made that only two groups of persons can afford to be ill, the wealthy and the very poor. The former are able to pay for what they get and the latter get a rather good type of service without charge.

The group that gives the greatest concern to students of the situation is the middle class. This group has been the victim of exploitation since the earliest times. It exists in one-room kitchenettes in the cities and must perforce go to the hospital in times of sickness. In the country and in the villages it is far removed from the available hospitals and pays mileage charges in addition to medical fees for medical attention. Because of its transient character it has fallen out of touch with the old-time family physician. This group, therefore, usually provides the primary source of revenue for medical quacks of every sort. The member of the middle class is likely to attempt to save the cost of a visit to a physician by purchasing a patent medicine widely advertised in the press or by asking the corner druggist

to prescribe. Middle-class workers are likely to join fraternal orders which maintain incompetent lodge doctors. Sometimes they work in large industrial plants or factories, where a certain sum is taken from their wages each week to pay for treatment in the factory hospital or for a visit from the factory doctor in time of sickness. As a result numerous leaders in the public-health field have urged the establishment of compulsory health insurance or other health schemes to provide funds for the care of the middle class.

Some economists have insisted on a State system of medicine which will provide health care in much the same manner as the State cares for education. Gerald Morgan, for instance, has insisted that there must be a radical change which will emancipate health in some way from the fetters of the existing acquisitive economic system, and provide free periodic physical examination regardless of known ailments and some financial provision for the families of those needing help in time of illness.

Professor C. B. A. Winslow, when president of the American Public Health Association, said that the purely individualistic practice of medicine, as it has existed in the past, must be increasingly supplemented by a form or forms of organized medicine which will offer to the individual modern scientific medical care including laboratory and specialized consultation service on an economic basis which will facilitate its application to the prevention of incipient disease — probably on some basis which involves payment of the physician through a common fund for the supervision of the health of an individual rather than for the treatment of a specific ailment.

The health-insurance scheme developed through the sickness societies of Germany has been the subject of debate ever since its establishment. The panel system in Great Britain continues to be the subject of discussion by both the medical profession and the public. That system grew out of what is known as contract practice, a system whereby families paid a regular fee each week or month to the physician for all of their care. The same system has been employed by trade unions and by lodges. Unfortunately contract practice resulted in scamped work, because the physician was invariably underpaid. Persons well able to pay took advantage of the opportunity to get service at minimum rates. In times of extraordinary illness the patient had to pay extra for special service or resort to charity. The medical profession was demoralized through political maneuvering for the most remunerative contracts. In 1911, under Mr. Lloyd George, the National Insurance Act, which gave rise to the panel system, was passed. Since that time it has been modified repeatedly. Any doctor can get on the list of those working under the act and there are in England, Scotland and Wales some 35,000 so registered. Of these fewer than 15,000 are actu-

ally doing national insurance work. About 1,000 physicians, constituting an active minority, refuse to have anything to do with the whole scheme. The number of persons insured under the act is approximately 15,000,000, so that the average number of insured persons in the care of one doctor is about 1,000.

When accepting appointment under the insurance scheme the doctor agrees to give such service "as can properly be undertaken by general practitioners of ordinary competence and skill." Thus those registered are not provided with the best that medical science can provide. The persons treated are those who do not earn above a certain minimum sum per week. The patient presumably has a free choice of physician, although this is governed by accessibility and the willingness of the doctor to take more patients on his panel. Some doctors have 400 on their panels, others 3,000. There are material benefits for prospective mothers, and there are minimum fees for doctors: the latter have never been considered adequate; in many cases the physician must supply the drugs prescribed as a part of the fee.

The American medical profession has looked with increasing concern at attempts to establish similar State systems in this country. For instance, the Committee on Public Policy of Ohio State Medical Association, at its last annual meeting, presented a resolution which was adopted by that State organization, objecting to every possible encroachment of the State on private medical practice. They objected to the extension of free clinics, to the growth of health-insurance ideas, to the widespread propaganda for nationalization of property and socialization of personal service, to the increase in health charity for those able to pay, to personal health service without charge in educational institutions, and to every other tendency of governmental agencies and departments, to interfere with the relationship between patients and their individual physicians.

The mechanization of medicine is an evil recognized by every physician as a menace to sound medical practice. Come what may, the intimate personal relationship of physician and patient is essential to complete relief of the patient's ills. Even the periodical physical examination is unsatisfactory when applied on an impersonal basis. True, it may detect the scientific evidence of incipient physical disease, but it does not get at the personality of the patient in the manner that formerly resulted from the relationship between the general practitioner and his patient. Even the best social-service technique may fail to find the human being that the old-time physician used to know in each of his patients. A single point in the life history of the ailing individual may explain the major part of his symptoms and his distress. Not infrequently that point is carefully concealed from everyone except the personal physician in whom the patient has the same confidence that members of some churches have in their priests.

QUESTIONS

- *What is “socialized medicine,” as defined by the author? Why is he against it? Are his concerns still relevant today? Why or why not? Do you agree or disagree with his reasoning? Explain.*
- *When and why was the American Medical Association formed? Whom does it represent? What are its goals? Why was it opposed to a new health care system? How influential has the AMA been since its inception? How does it achieve its influence?*

The evils of socialized practice, indeed of any impersonal method of medical practice, are generally recognized. They involve inadequate compensation for physicians: the average salaries of doctors in State or commercial organizations rendering such service are between \$3,000 to \$4,000 a year, notwithstanding the fact that an adequate medical education may cost the doctor approximately \$20,000 to \$25,000. The standards of medical practice are lowered because the tendency of the contract doctor is to see as many patients as possible. Patients are moved along without adequate attention. In some parts of the country doctors engaged in contract practice attempt to see eighty or ninety patients each day. The physician falls into the deadly routine of contract work, initiative is lost, and advancement is dependent on the individual's ability to pull wires.

Only too often industrial medicine has become an instrument for fighting compensation claims. The salaried medical services of department stores and of factories are so impersonal that many employees prefer, even though assessed for the provision of medical care, to seek out a personal physician in time of stress. Why should not a democracy attempt to insure the worker a salary or wage adequate to provide for medical treatment and ask the medical profession to organize itself for the provision of such treatment, rather than pauperize the middle class by degrading the medical profession?

More and more the advances in modern medicine reveal the essential differences between individuals that make routine methods of diagnosis and treatment impossible. More and more physicians are beginning to recognize the influence of the mind in disease and in the treatment of disease, a factor invariably lost in mechanized practice. State medicine might provide a standardized diagnosis and treatment for a standardized citizen, but it means the death of individualism, of humanitarianism and of scientific practice. Until we become a nation of robots with interlocking, replaceable, and standardized parts, there will be little need for completely standardized doctors.

The author is the editor of the Journal of the American Medical Association.

May 2, 1928:

In Defense of Socialized Medicine

By L. M. RUBINOW

OVER a million persons devote their entire time to the cure and prevention of disease and to the preservation of health of the American people, and yet complaints are numerous as to inefficient and insufficient medical

aid. There are many small communities without any medical aid at all and their number is increasing. There is a continuous development of medical quackery and cults. The patent-medicine trade continues to flourish. Self-medication is popular. Every health survey discloses a great proportion of existing illness uncared for. And it is the frank admission of the medical profession itself that most of the practice is not scientific.

What is the trouble? First, the average state of knowledge of the practitioner of medicine is tragically behind the present stage of medical science. There are some 150,000 independent practitioners in the art of medicine whose contact with modern medical science may be anywhere from one to fifty years old. Yet once authorized to practice medicine, the physician preserves this authority over our health, life and happiness, even as a deed remains a permanent letter patent over a certain piece of property. For the license to practice medicine is a property right and is logically to be considered such as long as the basis of our organization of medicine is the system of private practice, the income-bearing possibilities of a medical diploma and a medical license. This medical diploma and license confers upon every physician — every one of the 150,000 — the right to cure all the ills the human body is subject to. He may practice all branches of medicine from obstetrics to brain surgery, from ophthalmology to proctology. Now, it is a safe assertion that not a single one of the 150,000 is competent to perform all the services which legally he may undertake. Yet the organized state has not seen its way even to limit the healer's license somewhat more closely to the performance of what he is really competent to perform. For their protection, 110,000,000 patients are themselves expected to pass judgment as to the comparative merits of their physicians and surgeons. Now, it is hard enough to be an expert on the million and one material objects and services which everyone of us has to purchase in the course of our daily existence. But how are you to judge as to the knowledge, skill and wisdom of a physician? By the results? I challenge any statistician to work out a satisfactory basis. So we judge by rumor, appearance, personality, display, disguised advertisement, and bluff. In short, in the selection of the physician, the chance of obtaining competent medical aid is largely a gamble, a speculation, with the patient's health and life at stake. And no one better recognizes it, no one more forcefully admits it than the physicians themselves. But not openly, for that would be against professional ethics. Officially, the fiction persists that one reputable physician is as good as another, for they all have the right to sign death certificates.

Secondly, the practice of the art of healing today requires not only an amount of knowledge which, because of its very vastness, must be divided among many but also a vast installation of machinery and apparatus; in short, a capital investment

as well as skill. Hospitals and dispensaries, clinics and sanatoria, convalescent homes, laboratories and X-ray departments, institutes of hydrotherapy, electrotherapy, mechanotherapy, etc., assistants, bacteriologists, pathologists, radiologists, chemists, nurses, etc., these are the mechanical elements and human elements of the necessary medical organization for practicing the art of healing. Contrast all that with the average facilities of the private physician, not only with those of the general practitioner but even of the modern specialist.

The practice of medicine has grown beyond the powers of an individual physician. It is being organized and, to a very large extent, institutionalized. Already some 7,500 hospitals provide 800,000 beds, representing an investment of approximately \$5,000,000,000. There are some 6,000 dispensaries and clinics. Perhaps an increasing proportion of the American people receive all their medical help in these hospitals and clinics and dispensaries. But the curious anomaly is that economically private practice remains the form of organization.

There remains a third serious indictment of the system of private practice and the principle of private barter and bargaining, the cost of medical aid and care. The slogan "The very rich and the very poor are the only ones who receive the best kind of medical help" has become almost a bromide, so frequently is it quoted when the problem of medical organization is discussed. Like all slogans, it contains a half truth. It is, undoubtedly, true of the very rich. And only of some poor, those who are fortunate enough to be admitted into a first-class medical institution. For the vast majority of our people, a serious illness is a financial as well as an emotional catastrophe; the cost of cure is ruinous if not prohibitive. It is unnecessary to quote figures. No figures would be typical. But every American can quote illustrations from his own experience or that of his friends. What does a pneumonia cost? What an appendicitis? What the arrival of a new member of the family? What is the average price for any of the thousand different diseases, acute and chronic? There is no standard of cost. It varies not only with the locality but with the economic status of the patient and his family, with the particular notion, no matter how inaccurate, as to this status which the physician or hospital may form, with the commercial talent of the physician, with the particular valuation which the latter places upon his services, etc. What else but chaos may one expect in the price of a commodity, about the quality of which the purchaser has no way of forming judgment, but which he is more or less under compulsion of pain and fear of suffering and death to purchase in a hurry at a particular time? There is perhaps no other example in which the case for price-fixing is so strong, yet no step has been taken in that direction. Compare the excitement which almost precipitates a revolution among 6,000,000 people because of a threat of increasing the carfare

from a nickel to seven cents. Governments may fall and, for all we know, barricades may be built in the streets of New York City unless this problem is satisfactorily settled. And what are its implications — a difference of four cents a day or \$10 per annum per worker. But whether an appendicitis operation is worth \$50 or \$500 or \$5,000 seems to be nobody's concern.

Now, it is not at all necessary to look for panaceas or even "dangerous" social experiments for a way out of this tragic situation, where the health and life of individuals and even of entire communities have become a matter of barter and sale. The way out lies in the direction in which the practice of medicine is inevitably tending.

The forces which must be called into action are threefold: (1) Institutionalization; (2) Organization; (3) Socialization.

And of these three words, the third is the one which works as a bugaboo. Do what you will, there is a dangerous connotation in it. It is almost like a conditioned reflex, which makes a patriotic American shrink or jump, according to temperament, when this word is thrust at him. It might be an interesting field of investigation for Pavlov, Watson or any modern psychologist, as to what particular part of this dangerous word is responsible for the effect. One is tempted to revive the hoary anecdote of the Russian censor who prohibited Lester Ward's "Dynamic Sociology," claiming that the book dealt with dynamite and socialism.

There has been a good deal of objection to institutionalization of medicine, but this objection has been largely overcome. Opposition to free hospitals and clinics, and even to low-paid clinics as dangerous competitors, crops out among physicians now and then. But, on the whole, the medical profession has learned to tie up medical institutions to the prevailing system of private practice.

Of course, institutionalization presupposes a great deal of organization, but organization is necessary and is growing even outside of institutional practice. Private practice is not as individual as it was some time ago. The dependence of a general practitioner upon the specialist for expert help, the dependence of the specialist on the general practitioner for patients, the dependence of both the general practitioner and the specialist upon laboratories for diagnostic help, the dependence of all the above upon the private patient (with money!) for a source of income, indicates the high degree of necessary organization. "Group practice" is one of the many experiments in this field of organization. In absence of such, the organization is a crude one and for the suffering patient, an expensive one. He is driven from pillar to post, from one specialist to another, paying an exorbitant rate for the laborious gathering of the necessary information as to his condition, which in a well-equipped institution can be had at an infinitely smaller expenditure of time, effort, and money.

But what of “socialization”? Just what does the dangerous label imply? What is its content?

Whatever the word, what is necessary is an organized cooperative method of providing efficient, scientific medical advice and aid, at a lower social cost, and certainly at little or no cost at all to the patient at the time he is ill.

Does that sound radical or revolutionary, dangerous or socialistic? Are there not enough precedents in the supply of other social needs? Are there not enough precedents in the field of public health and even medical aid as well?

The field of public education is a very good illustration in point. There is no prohibition of private and individual education by private agreement and for a fee, there is no restriction of “private practice” in education, at least not in any democratic civilized country. But as it is considered socially of very great importance that every child be given a minimum of education, a public system of free education has become a self-evident necessity. Every child may take advantage of the system of free education furnished at public cost. The vast majority of them do, as a matter of course. Side by side with this, private educational institutions and even private individual teaching continue to exist and even to flourish. But a system of public, socialized education is a modern necessity.

Why do not the same considerations hold good for medical aid? Public socialized medicine need not be monopolistic and exclusive. It is not exclusive even in communistic Russia, popular misinformation notwithstanding. Private practice as such is not prohibited even to the physicians who are employed by the state. Nor is the principle of free medical aid at public expense unknown in this country. Hospitals and dispensaries furnish it. Municipalities and States and governments furnish it to a large degree.

Why, then, do we not speak of socialization of medicine as an accomplished fact rather than an ideal or a menace in this country? Partly because we are afraid of both the concept and the term. But more properly, because all the free medical work done here is permeated with an atmosphere of charity, because underlying it are the concepts of special consideration for the poor, the indigent, the economically dependent. There are, therefore, numerous restrictions, legal and moral, as to the rights of the individual to avail himself of these free services. These are all concepts which have disappeared entirely from the field of public education.

The difference is interesting. It may offer a fruitful field for investigation, in search of psychologic explanations. The encroachment of organized society on the field of private medical practice is resented not only by the group immediately concerned — the 150,000 physicians — but to some extent by public opinion, that uninformed and unreasoning public opin-

ion which accepts the medical profession's point of view of medicine as a trade or a business, and a profitable one at that, rather than a public necessity and, therefore, a public service. Instinctively, it draws this artificial line of distinction between education and medicine, because education has been and has remained a poor man's job, while medical practice has paid, in some cases, very handsomely — so handsomely as to establish that profession side by side with law as one of the possible roads to substantial fortunes.

Usually the arguments voiced against the further socialization of medical practice are noble and altruistic.

There are the menace of socialism and the defense of the great American principle of liberty. And there is the threatened deterioration of medical science if physicians become wage slaves. And, of course, there is the danger to the principle of free choice for physicians. And the necessity of preserving the intimate personal relationship between physician and patient, and so on and so forth. And, of course, one does not need to be a very profound student of Freud and modern psychology to recognize all these arguments as the most transparent kind of rationalization.

What is there so peculiar in the education, training, make-up, and work of the physician which makes it impossible for him to work for a salary as most of us in other professions do? Salaries have not prevented university professors from doing research in laboratories and judges from rendering just decisions. Already our greatest medical research and teaching institutions realize that a salary — and, of course a generous one with exclusion of private practice — is the only condition under which devotion to research and to honest hospital work can be assured.

And, of course, the weakest but the most interesting arguments against socialized medicine are those based upon the sanctity and intimacy of the doctor-patient relationship. To begin with, there is absolutely no reason why public or socialized medicine should destroy intimacy of that relationship or even the freedom of choice of that physician. There is nothing in the principle of free medical practice to justify that fear. Under such a system, as under the present system, there will be popular and unpopular doctors. Then, as now, this popularity or lack of it will often result from fortuitous circumstances, entirely independent of professional competence. But what the opponents of socialized medicine close their eyes to is that the old, sentimental, doctor-patient relationship is rapidly disappearing — in larger communities it has practically disappeared already, not through the influence of the free dispensary but through the commercialization of private practice.

The old family physician was a noble, picturesque, delightful figure, but no vain regrets will keep him alive or revive

QUESTIONS

- *What does the author believe are the major problems with the medical system? Are the problems he sees still relevant? Why or why not? What does he think will solve them? Comment on his assessment of the system and his fix. Between this article and the previous one, which is the more convincing? Why?*

him. Considerations, both professional and economic, drive an increasing proportion of young physicians into specialties and thus widen the sphere of the individual doctor's activities, at the same time destroying the old family-doctor relationship. The constantly rising scale of medical fees, the constant complaints of the masses against the cost of medical aid, the high proportion of unpaid bills, the necessity of seeking the help of collection agencies, the propaganda for application of business-like methods, all this may be inevitable but is hardly calculated to preserve the role of the family physician as guide, philosopher, and friend, as well as doctor.

And, after all, humanity is not so stupid as to be unable to see the tremendous advantage of a system under which the physician who examines and treats us has no interest in our pocket-book, in our ability and willingness to pay, no interest in recommending repeated calls or surgical procedure because of the promise of a fee, no other interest, in fact, than the professional interest in our symptoms, in their underlying conditions, and in the possibilities of overcoming them.

September 24, 1930:

The Doctor in Soviet Russia

By RALPH A. REYNOLDS

To appreciate the position of the doctor under socialized medicine in Soviet Russia today, one must know something of the medical situation in Russia under the old regime. As in many other spheres of Russian life, there were in medicine the most diverse extremes of backwardness and enlightenment. In general, the standards of medical education were high and certain experimental laboratories and institutions stood at the very forefront of the scientific world. One need hardly mention such names as Pavlov, Speransky and Orbelli, and, representing an earlier period, Pirogov and Metchnikov, to remind us of Czarist Russia's high achievements in medicine. In the cities, the clinics and hospitals varied in their efficiency and distribution.

Good hospitals could be found in all of the larger and many of the smaller cities, but there was no organized effort on the part of the government, either local or central, to insure medical attention to the mass of the people. Except for one or two experimental child-welfare centers, prophylactic and educational health work was unknown. In the country districts, generally speaking, medicine was administered by men who had failed to make a living for themselves in the city and therefore had been forced to accept the poorly paid country posts.

In all but exceptional cases the medical care of the peasants was notoriously bad. Limited as the amount of good medical service was, the number of doctors, good or poor, was even more limited. In many districts the proportion of physicians to inhabitants was one to 40,000. It was not uncommon for a man with a broken leg to have to drive two days to reach any one who could set it. In all Russia in 1913 there were only 12,677 doctors or one to every 12,000 persons. Of these 8,900 or 71 per cent lived in cities, leaving an average ratio of one doctor to 20,300 peasants. At that time the peasants comprised about 80 percent of the population. These figures are from the report of the People's Commissariat for the protection of health to the Twelfth All-Russian Congress in 1925. So great was the need for medical personnel that a type of semiqualfied practitioner, to be met with in no other part of Europe, came into existence in Russia. This was the *feldsher*. He was given a modified medical course of about two years (at that time the regular course was six years), he was prepared to do emergency aid work, to perform minor operations, and to prescribe for the more common diseases. Many of the medical outposts were staffed entirely by these *feldshers*, and in the cities they assisted the doctors in the operating room much as trained nurses do in America.

With these conditions, fair in the cities but utterly inadequate throughout the vast peasant districts, it is not surprising that there was a very high death-rate in Russia. In 1913, the last year when the old regime was in full force, the death-rate for all ages throughout Russia was 27.3 persons per thousand. The infant death-rate during that period was admitted to be very high, the highest of that of any civilized country — 27 per hundred in 1911 as against Norway's 6.5. So long, however, as the birth-rate was high enough to assure the normal growth of the population, little attention was paid to the death-rate. One responsibility the government did assume — that of prevention of widespread epidemics. Vaccination against smallpox was provided freely and research expeditions were sent into regions infested with the black plague and malaria. Even this work, however, was directed by no central health organization, the prevention of epidemics having been undertaken by a small division of the Department of the Interior. The army and the fleet had their own separate medical units; certain insurance companies were sending doctors to their clients; some cities had their public institutions, but in general the people's health was in the hands of private practitioners and of benevolent individuals.

The status of the doctor under this regime was much the same as is our status in the United States at the present time. Many were well trained, many carried on large private practices, many engaged wholly in research work, and more than 70 per cent were located in the cities. On the whole, they were

prosperous and happy, being members of the educated and privileged classes. Then came the Revolution of 1917, ushering in the Communist Government. One of the principles of this government is complete control of medical service by the state. Disease is considered not a person's private affair to be indulged as he sees fit. Disease is regarded as harmful not only to the person suffering from it but to the state of which he is an economic and social unit. The shifting of emphasis, therefore, has been definitely from curative to preventive medicine. The complete new program of public health was formulated in 1918, when the Commissariat for Health was organized. This foundation had as its main concepts certain fundamental principles: The unification of medicine; the accessibility of medical aid to all citizens; free medical treatment for citizens; medical treatment by a qualified personnel; the placing of emphasis on prophylactic work.

First the work of unification was accomplished. All the medical resources of the nation were organized into one centralized system. The doctors, *feldshers*, nurses, and pharmacists became civil servants, and all hospitals, sanatoria, and drug stores became state institutions. A standardization of hours of duty and of salaries based on professional responsibility and local economic conditions was worked out, the doctors' salaries now ranging from \$60 to \$120 monthly, programs of child-welfare work and campaigns against tuberculosis and venereal disease were prepared on a nation-wide scale; central institutions for research and teaching in various branches of medical science were established to which provincial doctors could come for post-graduate study. The wholesale preparation of drugs and the purchase of those produced abroad was undertaken as a state business, the cost incident to private production and advertisement being thereby eliminated. This move to unify the medical field did not in itself abolish private medical practice but it dealt it a death blow by supplying such adequate health service free that little or no place was left for private practice. The doctor was reduced to the capacity, economically, of a poorly paid employee of the state, and patients, instead of consulting their favorite doctor, were expected to go to the clinic or institute created for their particular group.

Now how did the government set about to make medical aid accessible to all citizens? The first need was that of increasing the total number of well-trained medical men. This result was partly accomplished by the government supporting practically all medical students through their entire course of training, the support extending even to spending money. Moreover, public opinion under the Communist regime places great value on social service and on scientific knowledge applicable to human needs. This attitude naturally encourages young people to take up a medical career. Of financial remuneration there is of course very little, and the most eminent scientists live in

cramped and depressing quarters. Still their lot is, in a material way, no worse than that of their neighbors, and their work is such that they are looked upon with respect. All these factors may have encouraged students to enter the medical field. At any rate, the year 1928 found the total number of doctors increased to 44,800 — nearly four times as many as in 1913. Incidentally, it is interesting to note that whereas before the revolution only 28 percent of all medical students were women, at the present time the women comprise more than half of the students in the graduating classes.

While increasing thus rapidly the total number of doctors in Russia, the government set about at the same time to arrange a more adequate distribution. As fast as medical students graduated they were sent out into the rural districts, each to give three years' service wherever he was sent. This compulsory three-year period among the peasants is considered just payment for the training and support the student has received at the hands of the government. If during the three-year period the young doctor makes some outstanding contribution to the science of medicine, he may then choose his own location and type of work immediately. This process of equalizing the opportunities for medical aid throughout Russia has already made marked progress, though the need in the rural districts is still great. There is now one doctor to every 14,000 peasants, as against one to every 20,000 in 1913. By carrying on the same plan the government expects, by the end of 1932, to increase the number of doctors in the peasant districts by 40 percent.

How does the system really work? In what way does the patient actually come in contact with the physician? Let us consider, for instance, the Railway Workers Clinic in Moscow. It is designed to serve the clinic needs of 100,000 railway workers and their families — in all about one-half million men, women and children. These workers are employed by four different railway systems which have station terminals and other facilities in Moscow. The companies which are now operated by the state protect the worker and his family by a system of social insurance. This entitles the workers to many privileges, such as old-age pensions, partial support of the unemployed, extension of free medical aid to all ill or crippled workers, vacation of workers on full pay, treatment in sanatoria, time off from work with full pay to care for a sick member of a worker's family, and many other privileges. Such an all-embracing social responsibility is naturally expensive, and anywhere from 15 to 20 percent of the wage bill of any business enterprise, whether under state or private ownership, must be set aside from the proceeds of the business to cover this tax. However, it takes the place of most of the public and private funds in other countries, since it aims to care for all sick and aged workers and those dependent upon them. Offices of the organization are set up in every

community where there are 2,000 or more persons eligible for insurance. The Central Headquarters in Moscow outlines the general principles and coordinates the social insurance work in all parts of the country, settles disputes, and carries on an educational campaign regarding the benefits to be obtained by the state insurance.

The railway clinic, which may be taken as a typical one, subsidized by the social insurance fund, employs 143 full-time physicians and 40 more who attend to necessary calls in patients' homes out of clinic hours. The average number of patients treated daily in this clinic is about 3,500. Each doctor must see a certain number daily — for instance, each internist must see 35 patients daily, each pediatrician 28, each neurologist 30, each ophthalmologist 40, each dentist 18, each surgeon 45, each ear, nose, and throat specialist 40. In addition to the doctors on the staff and other employees, there are 18 dental chairs occupied constantly, and the department of dentistry makes and distributes 30,000 artificial teeth annually. There are also departments for making artificial limbs, body braces, spectacles, crutches, and other similar apparatus, and for issuing free medicines, bandage, and supplies.

The doctors are paid a salary by the company out of the Social Insurance Fund which, of course, is a fund of the state. They devote their full time to the work, spending about six full hours daily actually at work in the clinic. The rest of his time the doctor has free to spend as he chooses. If he wishes to do research work at home, the state gives him an additional room and the necessary supplies. Large clinics, such as the railway workers' clinic, publish medical journals of their own, and every month various phases of the work are described. It is interesting to note, under the Soviet system, that the workers do not pay anything toward this Social Insurance Fund, the expense being borne by the factory or industry concerned — in the last analysis, by the state. When, however, a question arises as to the right of a worker to any kind of compensation, the doctor sits in conference with a committee of workmen rather than with officials. It is said that the workers' committees are inclined to discipline their fellow-workers more severely than the officials of the companies would do. If a worker is definitely caught malingering, his punishment is expulsion from the labor union and loss of his rights of social insurance.

As far as I could recall, the quality of medical work performed was good. I realize that what I saw was perhaps the best. However, as I went through the clinics, both the large city institutions like the ones described and the general country clinics in the peasant villages, it seemed to me that the work which was being done was about the same as that in our university and other free clinics. Moreover, it was, I think in most cases, better organized. I feel certain that the surgery I saw in Russia

was better than that which I saw in some of the other European countries. The surgical and medical equipment was distinctly superior to that used in most of Vienna's hospitals.

The physicians in charge of the important institutes in Russia were, for the most part, leaders under the old regime. These older men, like Pavlov, Orbelli, Speransky, and Burdenka, have been responsible also for most of the research work produced under the Communist Government. However, during the past two or three years the younger men have begun to contribute to the medical literature. According to the bitterest critics of the present system some really good experimental and clinical work is now being contributed by the younger men, trained under the new regime. The type of training they have received is not unlike that received in our own medical schools. The medical student completes a five-year course and from one to three years in a hospital. If he specializes as most of them are now doing, he is required to do four months' post-graduate work in his specialty every two years. These post-graduate courses are well organized and are very popular. In addition to the scholastic type of post-graduate work, a great deal of practical group study and investigation is going on constantly in the larger institutions. As an example, the Venereological Institute in Moscow, in addition to the 150 physicians regularly employed full time, has 50 physicians from the provinces there, constantly studying modern methods of treatment and conducting research. As to the result of investigation and study, we all know that a tremendous amount of material is being published. Much of it, of course, is worthless, as is the case in any country. Since, however, the system of socialized medicine brings an enormously increased number of patients under observation, and since autopsies are compulsory, it is clear that Russia's scientists have a tremendous fund of organized information from which to draw conclusions.

A widespread and thorough public-health program is one of the planks of the Communist platform. The organization of this department has been chiefly in the hands of Professor Semashko. Each republic in the Soviet Union has its own commissariat of health but they are all under the central Commissariat of Health in Moscow, of which Professor Semashko is the head. He undertook the work of organization at a time when prevention in medicine was the slogan. It expressed a new point of view in Russia and it fitted admirably into the new Communist sense of values.

But what of the doctor? I have described sketchily how he plays his important role in the new order. Many excellent results of his work are manifest. But, as one brilliant physician, the head of one of Russia's best-known institutes, complained bitterly to me:

How can we do our best work, when we must go from our laboratory to small, poorly heated, dingy, depressing quarters?

Even our laboratory animals are better housed than we. To be sure, our living conditions are better than in the early days of the revolution, yet still our rooms are over-crowded and we must share our kitchens with four or five other families. It is true that we pay very little rent for these rooms, and that we receive enough money from the state to support ourselves and our families, but a man needs more than bare support. He needs a place, even though small, that he can call his own. He needs to see his family decently clothed. He needs to be free from the eternal system. It is an invisible something one feels and finds oppressive even though one may have a reasonable amount of freedom in one's work. You American doctors do not realize how fortunate you are. It is interesting for you to come here and study our system. It is true that the whole of Russia is an interesting experiment, but it is not pleasant for us to be the experimental dogs and guinea pigs.

So speak many of the professional and business people of Russia. They have been reduced to the same state, economically, as the peasant and laborer without opportunity to regain economic independence. The doctor's success is now measured by the contributions he makes rather than by the size of his practice. It is too early to judge whether this policy is bringing a more or a less desirable type of men and women into the medical field.

What is the significance to the American medical profession of the status of our profession in Russia? The vision of great medical leaders reduced to poverty and submission is naturally discomfoting. The idea of the loss of private practice, and the socialization of medicine being to us more or less distasteful, our reaction is likely to be one of rebellious opposition. Yet blind opposition will avail us little. The medical profession makes up only a small minority of the population and it behooves its members to consider the trend of public opinion throughout Europe since the war.

Germany adopted a Social Democratic form of government with a national plan of social insurance and modified state medicine. Austria became a republic and Vienna adopted a socialistic form of government with a system that makes free medicine available to 1,600,000 of her 1,800,000 inhabitants. This, by the way, leaves only 200,000 as potential private patients for Vienna's 4,000 physicians. Czecho-Slovakia and Poland became republics with modified plans of social insurance. England has recently elected a Labor Government and the plan there is to develop the public health system along most liberal lines, the benefit being to the public at the expense of private practice. Medicine and health are becoming the business of the state.

The American system — the whole mental attitude underlying our professional and business life — has as an integral part the factors of personal initiative, competition, and reward.

QUESTIONS

■ *How is the Soviet medical system organized? How well does it function, according to the author? Compare and contrast it to the descriptions of the American healthcare system. Which is the superior system in your opinion? Why? Find out more about the impact the Soviet system had on the health of its citizens. Could the Soviet system be adapted to work in the United States? Why or why not?*

Many of us would deplore a change which would do away with these factors. On that very account, we must recognize the fact that socialized medicine under such a system as that of Soviet Russia is offering the public advantages of tremendous value. The best of these advantages can, I believe, be incorporated into our own system without displacing it, and it is to our own advantage to see that some such drastic measures are taken. If we fail to do so, socialized medicine may very likely be forced upon us.

November 6, 1937:

“Organized Medicine” Sees Red

By JAMES RORTY

IN THE very shadow of the White House “socialized medicine” has again raised its ugly head, and the vigilantes of “organized medicine” have sounded the alarm. During the week of October 25 the Group Health Association of Washington, DC, opened the doors of its group clinic to almost a thousand employees of the Federal Home Loan Bank, the initial membership representing about two-thirds of the Washington staff of this particular New Deal agency. In return for a check-off of their salaries of \$2.20 a month for individuals and \$3.30 a month for families, the Group Health Association contracts to give its members complete medical care, both preventive and curative but with emphasis on prevention, plus hospitalization for twenty-one days when needed. The corporate and administrative set-up of the association is modeled closely after the highly successful Stanacola Health Association of Baton Rouge, Louisiana, and the declared motives of the Home Loan Bank administrators in fostering the enterprise are as frankly practical as those of Standard Oil executives.

The director of the FHLB made this very clear in a paper read on October 5 before the Civil Service Assembly at Ottawa, Canada. What stirred the FHLB into action was its discovery that it was losing about half a million dollars annually through the sickness and lost time of its 16,000 employees in Washington and elsewhere. Since the FHLB, unlike many other New Deal agencies, has to pay its own way and compete with other dealers in mortgages and real estate, Mr. Zimmerman, the director, and his associates decided that they could not permit this loss if it could be prevented. In addition, the FHLB, still keeping well within the pattern of hard-boiled business motivations, wanted to attract and keep desirable employees by becoming known as a “good employer.” The logic of these considerations sug-

gested the establishment of the familiar group-practice, group-prepayment type of health service, organized and administered cooperatively by the patients it is designed to serve, but with strict medical control of medical functions. As Mr. Zimmerman pointed out, experience has shown that families with incomes of less than \$3,000 cannot and do not budget the unequal and unpredictable costs of medical care, but the higher ranks of skilled workers and white-collar employees are able to insure voluntarily against these costs, just as they insure against fire, burglary and automobile liability. They can also take advantage, through cooperative organization, of the substantial economies and efficiencies yielded by group medical practice.

When the idea was broached last spring at a meeting of the FHLB employees, they approved it enthusiastically. Accordingly, expert advice was obtained from the Health Economics Association, an offshoot of the Twentieth Century Fund, and the Group Health Association was incorporated under the laws of the District of Columbia. About a thousand employees were enrolled, a highly qualified medical director was obtained in the person of Dr. Henry R. Brown, formerly chief of the tuberculosis division of the Veterans' Administration, and a staff of six physicians was engaged on full or part time.

If there is any red fire in any of this, it takes a special kind of magnifying eye to see it; such an eye, in short, as the American Medical Association has consistently turned on all developments looking toward fundamental change in the organization of medical care. As it happened, the A. M. A. held its 1937 convention at Atlantic City just about the time that the Group Health Association was being organized. From this convention, signalized by the A. M. A.'s belated discovery of birth control and the mildly progressive but instantly emasculated resolutions introduced by the New York delegation, the lay public got the impression that "organized medicine" was trying to improve its manners, at least, and possibly even its methods and attitudes. But the *New York Medical Week* of June 19 poured cold water on this optimism. And in the *Journal* of the A. M. A. of July 3 Dr. Fishbein made the defense of the status quo authoritative by affirming again the A. M. A.'s "ten commandments," adopted in 1934, which condemn both voluntary and compulsory health insurance and indeed almost any creative change in the organization of the health services.

In the light of subsequent developments it is clear that the seeming liberalism of the 1937 convention was either window-dressing or an abortive palace insurrection stemming from the group of progressive physicians mobilized for the American Foundation study, "American Medicine Expert Testimony Out of Court." For while the convention was still in session the House of Delegates got wind of the organization of the Group Health Association and promptly went into executive session.

Alarums! Tocsin! In Washington the telephones of Senators and Congressmen began to ring. What was the Group Health Association? Please get us all information regarding this new threat to the preservation of rugged medical individualism.

The statesmen tried but were told that Dr. Brown, who alone could answer their questions, was traveling in the West. So determined was the pressure of the medical hierarchy, however, that Senator McCarran at first threatened a Congressional investigation of the FHLB. Later, when the facts of the case were put before him, he changed his mind. Some of the harassed statesmen are in fact reported as muttering — off the record, of course, like the doctors who contributed to the American Foundation symposium — that the A. M. A. itself might benefit from a little investigation.

But the vigilantes of “organized medicine” were not easily balked. They found a sympathetic ear attached to the dependably reactionary head of David Lawrence, who in his column in the *New York Sun* of August 26, 1937, declared:

Physicians throughout the United States will be interested to learn of the New Deal’s latest experiment, which may prove the entering wedge for “socialized medicine” in America, sometimes called the placing of medical care on a “quantity-production” basis... The new organization [Group Health Association, Inc]... is directly in line with what has been urged by persons inside the Administration who see the job possibilities and patronage potentialities of medical bureaucracy in the government... The way “socialized medicine” would develop would be to discourage younger men from going into the medical profession and take away from those who have built up a practice many of the patients who ordinarily come to them...

Besides these and other profundities which Mr. Lawrence offered as his own contribution, he quoted a number of American, British, and German doctors in criticism of compulsory health insurance, while chastely withholding from his readers the overwhelming evidence that health insurance abroad, despite its admitted defects, has on the whole immensely improved the condition of both patients and doctors.

Mr. Lawrence’s alarm focuses on a provision of the Group Health Association’s by-laws which permits it to recruit as members not only employees of the Federal Home Loan Bank and the Home Owners’ Loan Corporation but also “employees of any branch of the United States government service... other than officers and enlisted men of the United States army and navy,” in case this enlargement of its scope is approved by the board of trustees and by the membership.

A similar apprehension afflicts the A. M. A.’s Bureau of Legal Medicine and Legislation, which contributes to the October 2 issue of the journal an eight-page bitterly hostile analysis of the Group Health Association. Eventually, the bureau asserts,

the association might come to serve some 115,912 government employees and their families resident in Washington or within ten miles of the city limits. Presumably if this happened it would be because the Group Health Association served well the needs of its members and offered salaries and conditions of employment sufficiently good to attract and hold a competent medical staff. It would mean only that the Group Health Association was doing a better job than, for example, the so-called "Washington plan" set up by the District Medical Society. The latter is little more than a medical collection bureau, designed to assist poor patients in paying their doctors on the installment plan. Thus far the Medical Society's enterprise has solved no problem and satisfied nobody except some of the participating doctors.

In its attack on the Group Health Association, the Bureau of Legal Medicine and Legislation relies chiefly on its version of the law as it affects the conduct of a membership corporation, the practice of "corporate medicine," and the like. According to its interpretation of the law the Group Health Association is illegal. At one point the article went so far as to say:

If and when Group Health Association begins to practice medicine as proposed in its certificate of incorporation and by-laws, the United States district attorney and the corporation counsel for the District of Columbia, in pursuance of their respective offices that they have sworn to perform, will be bound to enforce the law.

The bureau intimates that the members of the association may find themselves personally responsible for its debts and torts, and it pretends to find a further illegality in the check-off system as applied to the salaries of government employees.

Since the Group Health Association has had able legal advice, and since similar enterprises — the Stanacola Health Association, for example — have not been successfully challenged despite the tangled statutes which in most states beset the path of pioneers in voluntary health insurance, the bureau's magisterial pronouncement is probably bluff. If history repeats itself, our medical politicians will do little more than make life hard for both President W. F. Penniman of the Group Health Association, who incidentally is assistant administrator of the Federal Home Loan Bank, and Dr. Brown and his medical staff, to the extent even of expelling them from the District Medical Society for "unethical conduct." But this has been endured before by other pioneers and presumably can be endured again. The question that is immediately posed is whether or not the American Medical Association will be permitted to veto a progressive and commendable enterprise by an important New Deal agency, an enterprise designed simply to assist its employees in their effort to provide themselves with protection against illness by methods not essentially different from those which

QUESTIONS

- *Why was Group Health organized? How was it set up to meet the needs of its members? Why did the A.M.A. decide to fight Group Health? Why did it declare it to be illegal? Do you agree or disagree with the A.M.A.'s interpretation of the law? Find out what happened to the Group Health Association. Was it able to serve its members? What, if any, were its accomplishments? How did it influence the building of other similar organizations? Did they have to fight similar battles? Why or why not?*

the more enlightened private employers have successfully utilized for years.

June 23, 19435:

Who Fights Health Insurance?

By GERALDINE SARTAIN

THE BATTLE against health insurance is on again, this time characterized by several new developments. The most important of these are the advertising campaigns produced by the organized medical profession in its last-ditch stand against what it calls "socialized medicine." One campaign uses the press as its medium and another the air waves. It is interesting to note that in order to underwrite this type of propaganda the doctors had to do a complete about-face and lay aside their traditional opposition to paid advertising.

Even before Senator Wagner introduced the streamlined Wagner-Murray-Dingell bill on May 24, the organized medicos had gone into action. For the fear of "political medicine" has hung over the American Medical Association ever since the late thirties, when Senator Wagner first introduced an extended social-security measure containing insurance provisions that would enable 135,000,000 people to receive comprehensive medical care. His present bill also would provide every man, woman, and child in the country with good medical care, paid for by 1.5 per cent of every wage-earner's pay check, plus a like sum from the employer, plus 3 per cent of the earnings of the self-employed, plus government taxes to cover the indigent.

Through the National Physicians' Committee for the Extension of Medical Service, which has the blessing of the A. M. A., a series of six paid advertisements entitled "Editorials to Editors" and designed to reach the thousands of newspaper editors in this country began running last month, in *Editor and Publisher* and other newspaper trade journals. Each of the series contains a statement of policy in which the committee frankly admits that it "is utilizing to maximum capacity its resources and organization strength in ceaseless efforts to preserve our system of private enterprise." Nothing is said about preserving the health of the nation.

The advertisements urge editors to tell the American people what perils await them: that their "priceless heritage," the private-enterprise system, is endangered; that "the sacred relationship between doctor and patient" is similarly threatened (no mention is made of the millions of our people who have

virtually no relationship with doctors, sacred or otherwise, because they haven't the money to pay for it); that "the sanctity of human personality" will be undermined; that doctors are "to be regimented and made subordinate to the bureaucrat, and the people forced by law to accept such medical care as could be provided by a politically appointed bureaucrat."

John M. Pratt, author of the series, executive administrator and publicity man for the committee, has explained that the idea of propagandizing newspaper editors — at a cost of \$7,000 for the six advertisements — was the result of two years of experiment on various approaches "to a very delicate public-relations problem." The problem was solved by slanting the editorials so they would arouse fear, while dark hints that health insurance "is a fatal step toward complete totalitarian control over the lives and destinies of all men" play further upon the emotions.

The radio campaign is a large-scale attempt at direct popular propaganda, using the fear technique also, but more subtly. A weekly fifteen-minute radio series called American Medicine started last fall over twelve stations of the Michigan network under the auspices of the Michigan Medical Society. Now this is planned as a national program to be put on by the medical societies of sixteen states and the District of Columbia. It is a disarmingly friendly program, made up of sweet music with a final commercial plug just before the theme song, "When Day Is Done." This plug contains "a brief message from your family doctor" warning the listeners that "no theoretical plan, government controlled and operated and paid for by taxation, should replace the present plan, which allows you to choose your own doctor." Actually the Wagner-Murray-Dingell bill specifically safeguards Mr. and Mrs. America in the right to choose their own doctor and the doctor in his right to choose or reject his patients, as well as to join the new health-insurance system or remain outside it.

The proposed national radio show was auditioned recently by the heads of the seventeen medical societies meeting at the headquarters of the Wayne County (Michigan) Medical Society in Detroit. They promptly voted to underwrite the cost. According to the amusement magazine *Billboard*, the program "is angled at the hottest potato in the field of medical practice today, namely, the Wagner-Murray-Dingell bill now before Congress, which sundry medical societies, backed by anti-Administration pressure groups, have widely smeared with the label of "socialized medicine." A station in Detroit will originate the program and feed it to a special network hook-up of eighteen high-power stations if they accept the program.

Some of them refused it after *Billboard* ran a streamer line on its almost full-page story, plus an editorial, warning the radio industry that such special pleading presented in the guise of entertainment is bad for radio. *Billboard* pointed out that the program American Medicine was first turned down

by CBS and by stations owned and operated by Columbia because it was controversial. It quoted C. K. Chapman of the Detroit advertising agency handling the program to the effect that it would reach 71,000,000 listeners in 90 per cent of the radio homes at a cost of \$70,000 for thirteen weeks. This cost included an \$8,000 appropriation for special promotion material to be distributed by doctors belonging to the sponsoring medical societies.

It was figured that the program would cost the 75,000 physicians belonging to the seventeen societies 7 cents a week, or less than \$1 a member for the thirteen-week series. The Michigan Medical Society has already spent \$21,000 for radio within the borders of the state, *Billboard* estimates, starting with a five-minute show over twelve small stations which was later stepped up to fifteen minutes. Its current program is a dramatized sketch based on "true-to-life" medical experiences from listeners' letters, the bait for the letters being a weekly prize of \$35 in war bonds.

These two campaigns, although new and somewhat startling for the medical profession, are a logical development of its line of propaganda during the last few years. The trade association of organized medicine, the American Medical Association — which fought hospital insurance and prepayment health plans in general until it lost its battle against medical cooperatives in the United States Supreme Court — has long been the spearhead of the fight against both compulsory national health insurance and state legislation providing the same benefits. It has now united with some drug manufacturers and casualty-insurance companies, and seeks to woo big business in general. In California the State Medical Society, with the help of chambers of commerce and other business groups, was able to bottle up in committee both Governor Earl Warren's compulsory health-insurance bill and a similar bill put forward by organized labor.

The National Physicians' Committee for the Extension of Medical Service, sponsored by the A. M. A., has for some time been engaged in a double-barreled, three-year campaign, for which it is raising a million and a half dollars to kill the Wagner-Murray-Dingell bill and to push health insurance coverage by commercial insurance companies. The committee is pursuing this course despite the fact that commercial health insurance offers no medical services but merely cash benefits for hospitalization and surgery — in other words, provides for catastrophic illness only and ignores the preventive aspects of medical care. Moreover, since commercial health insurance offers coverage only to people belonging to sizable employed groups, the great masses of the population are ineligible for its benefits.

At a public meeting last year the committee held out to these companies the lure of a billion dollars in new business. It has already circulated, through drugstores, doctors' offices,

and other media, millions of copies of a pamphlet attacking the Wagner-Murray-Dingell bill as “political medicine and the socialization of medical practice in the United States.” Some *Nation* readers have doubtless received this pamphlet enclosed with their doctors’ bills or the packages their druggists hand them. In addition, the committee sends regular releases to 12,000 publications to scare the public away from all government plans, state or federal.

All of this is happening in the face of Senator Wagner’s clear-as-glass statement and the plain language of the bill itself, Senator Wagner has said:

Health insurance is not socialized medicine; it is not state medicine. It is simply a method of paying medical costs in advance and in average amounts . . . of assuring a person ready access to the medical care that he or she needs by eliminating the financial barrier between the patient and the doctor or the hospital. Therefore it should be obvious that health insurance does not involve regimentation of doctors or patients. Neither do I believe that the doctors of this country will lower the standards of medical care simply because they are guaranteed payment for their services. . . . Social insurance has not interfered with our system of free enterprise; on the contrary, it has helped to make our system of free enterprise operate more smoothly and effectively.

Similarly, Arthur J. Altmeyer, chairman of the Social Security Board, has said:

We think a good program of social security is absolutely necessary if we are to continue to make economic progress, maintain a stable society, and promote a more productive system of free enterprise. When we loosen the chains of fear, we really give enterprise a tremendous boost.

In their opposition to compulsory health insurance the A. M. A. and its allied groups have been joined by the American Bar Association, the United States Chamber of Commerce, some other business groups, hospital organizations with a vested interest in voluntary health insurance, some of the farm agencies, the Health and Accident Underwriters’ Conference, which has a vested interest in voluntary plans because of the 30,000,000 health and accident policies and the 16,000,000 hospitalization policies in the United States, the American Taxpayers’ Association, and similar groups pledged to keep taxes down. On the other hand, all branches of organized labor are for it, and so are the National Farmers’ Union and the National Lawyers’ Guild. And one must point out that several organizations of progressive physicians have emerged in the last few years. The most important is the Physicians’ Forum, the chairman of which is Dr. Ernst Dons, distinguished New York heart specialist, son of the late renowned anthropologist, Dr. Franz Boas. The Forum is an expanding and militant body with growing influence in both professional and lay circles. It is pledged

QUESTIONS

- *Why was the A.M.A. so opposed to the Wagner-Murray-Dingell bill? What was the bill's fate?*

to support the Wagner-Murray-Dingell bill and corresponding legislation. The Committee of Physicians for the Improvement of Medical Care, a small, compact group made up mostly of doctors on the staffs of top-rank medical schools, is another progressive medical body supporting national health insurance. The battle lines are drawn. Hearings before the Senate Finance Committee and the House Ways and Means Committee are promised for this year. Only a few years ago health insurance was a social problem perceived and understood by a mere handful of persons. Today many national polls show that it is wanted by the majority of the American people.

November 10, 1979:

The Battle of Health Care

By TOBY COHEN

IF OURS IS indeed the culture of Narcissism in the Me Decade, the pundits of the new selfishness will have to explain why, after, some ten years of talk about enacting national health insurance, the middle class hasn't raised its collective voice in support of Senator Edward Kennedy's custom-built, all-inclusive health plan and against President Jimmy Carter and Senator Russell Long's national health care — for the middle class a very large empty box. Not empty for the welfare poor and the elderly, to be sure; virtually all of their medical needs will be paid for by the taxpayers under the Carter-Long plan.

Senator Long makes it all sound reasonable: "The polls indicate that the overwhelming majority of the American people are not concerned about being insured against run-of-the-mill hospital bills or run-of-the-mill doctor bills. What . . . is a matter of very serious concern to them is . . . catastrophic medical bills that wipe out all their savings, and they're properly concerned about that kind of risk. That's the area we would seek to take care of." But a comparison of the Carter-Long plan and Kennedy's all-inclusive, Scandinavian-style health insurance plan reveals the speciousness of Long's argument.

In the first place, by emphasizing "catastrophic" costs instead of more routine medical expenses, the Carter-Long plan ignores the consensus of opinion among health experts that both to insure better care and to lower costs, medical care should be expanded outside of hospitals, and people encouraged to visit the doctor's office before their problems progress to the hospitalization stage.

The Carter-Long bill would require all employers to provide their employees with government insurance that would cover all doctor and hospital bills after a family has spent a

total of \$3,500 (\$1,900 for a single person) on medical bills in a given year. Dentistry, drugs and long-term nursing care would be wholly excluded from reimbursement. To cover bills up to the \$3,500 cutoff, wage earners and their employers would be allowed to buy, besides the required Carter-Long Government insurance, additional private policies, or to maintain those they now own: The Carter-Long plan would cost the nation \$24.6 billion, which averages out to roughly \$205 per taxpayer for the first year, \$6 billion of which would be paid by employers. It would also buy most wage earners nothing. Only 10 percent of the population are not at present covered for hospitalization — but 40 percent are unprotected against doctor bills. Most private comprehensive major-medical policies would cover all these people, cost the taxpayers less than Carter-Long, and deliver more.

What catastrophic medical costs would Carter-Long protect against? Cancer, stroke, heart disease, heart transplants, severe accidents or burns — these so-styled catastrophic events usually require the patient to stay in the hospital only ten to twenty days. Renee Katz, the New York City high school senior whose hand was severed under a subway train and later reattached at Bellevue Hospital, stayed there only twenty days. Any basic Blue Cross policy would have covered her hospital costs. In fact, only 1 percent of the population will ever find themselves in a hospital for so long that Blue Cross coverage runs out.

But should someone fear that he might be part of that 1 percent, which protection would he prefer — the Carter-Long plan, with a \$3,500 deductible, or a currently available comprehensive major-medical plan that anyone can buy for roughly \$1,500 that requires a \$100 deductible, and supplies 80 percent coverage up to \$2,000 in bills and 100 percent after that? Consider: the total out-of-pocket costs — premium, deductible and coinsurance of such a plan would cost \$2,000, \$1,500 less than the Carter-Long deductible, whose coinsurance first starts at \$3,500. Its illusory value aside, what is catastrophic about Carter-Long is its potential effect on future medical costs. Says Dr. Sam Wolfe, chairman of Columbia University Medical School's Department of Public Health: "Whenever you insure the most expensive form of medicine over less costly and simpler medicine, you insure that expensive medicine will be more widely practiced." Moreover, when only the worst that could happen is insured, many people who now lack coverage for ordinary doctor bills will, in the early stages of a disease, when they could be most helped, for minimal fees, decide not to see the doctor — will wait, instead, until their disease is more serious, expensive and very possibly fatal. Every time someone is hospitalized because he or she waited too long to see a doctor, the cost registers in higher insurance premiums for all of us. In addition, the more illnesses the physician treats in their serious

phases, the more his fee goes up for everything, says Dr. Jacob Fine, Professor Emeritus of Surgery, Harvard Medical School. The result is that fees in general rise, in turn boosting insurance payouts. Patients without coverage for ordinary doctor bills also tend to press their doctors to hospitalize them, instead of treating them in the office, or on a house call. Solely to offset the potential overuse of hospitals, the Carter-Long plan calls for vastly increased inspection and regulation, which will add to the costs of the total program.

If the wage-earning taxpayer is to buy all of Carter-Long and get nothing, the welfare poor (now covered by Medicaid) and the elderly (now covered by Medicare) need buy nothing and do very well. Carter-Long handsomely increases their Federal benefits while putting both groups under one national health plan called Health care. Physicians would be prohibited from charging Health care patients directly and would instead be paid by the Government according to a fixed-fee schedule. The Carter-Long plan assumes that doctors will use that fixed-fee schedule as a “voluntary guideline” for their fees to others — but no law compels them to do so. Just possibly, doctors will warm to the President’s fantasies and not charge regular patients any more than they would their Health care patients. But more likely, with the fees for the poor and the elderly rigorously fixed, doctors will raise their fees swiftly and steeply for patients they bill directly, who may or may not be reimbursed later (remember that \$3,500 deductible) by insurance.

In contrast to the Carter-Long plan, the Kennedy Health Care For All Americans Act would cover all medical care for every American through indirect government payment to doctors. No \$3,500 deductible, no waiting by the patient to be reimbursed. Initially, dentistry and drugs (except for the elderly with chronic diseases) would not be covered and insured psychiatric office visits would be limited to twenty a year. Mindful of the rising costs of medical care, Kennedy’s system puts all medical care on a national budget much like the defense budget, and provides that this budget may expand only in proportion with the national economy. Then it allocates the budget by state and by type of service, and requires that allocations be lived within, to control medical cost inflation. From these budgets, the system would pay the physicians under negotiated fee schedules, and pay the hospitals according to negotiated sub-budgets for the year. The Kennedy program would also monitor hospitals and doctors monthly to see that they are living within their allocations.

The Government would not pay medical costs directly but instead would employ the insurance companies as both budget monitors and fiscal intermediaries. In turn, the insurance companies, together with hospitals, physicians, labor-union leaders, employers, consumers and Government representatives

would hammer out the yearly budgets. Should the insurance companies fail to enforce budget compliance through monitoring, they would pay overruns out of their own coffers and be prohibited by law from raising their premiums that year to compensate themselves. Yearly budget estimates would be reckoned in much the same way that the defense budget is reckoned each year — amply. Should unexpected medical costs arise even so — because of an epidemic like Legionnaire's disease, say — the national boards would have contingency funds available.

Last, but by no means least, patients would be free to choose any physician they liked, and the Kennedy proposal would also allow them to buy or maintain additional medical insurance. But except for dentistry or extensive out-of-hospital psychiatric treatment, there would be no need for it

The insurance companies would pay the doctors and hospitals from the premiums paid to them by employers, consumers and the Government. The cost of premiums to the employed would vary from 0 to 2.6 percent of their weekly paychecks, depending on their incomes. But in no instance would the premiums exceed \$800 a year, and that maximum would apply only to persons making more than \$30,000 a year. The remainder in all cases would be paid by employers. Those employers now required by union contracts to pay all health insurance premiums for their employees and those who pay without contract would in general continue to do so. Those who are not now paying the premiums for their employees and who could prove they cannot afford to would be subsidized by the Government. The Government would also pay the premiums for the elderly, for those unemployed with an income under \$2,000, and for the self-employed making less than \$2,000. Those above the cutoff would pay 2.5 percent of their income for their premiums. If they forgot or chose not to buy Government insurance, they could still go to the doctor whenever they had to. The doctor would be required to submit the bill to his state health board, which would pay him and be reimbursed by the Government. The Government, in turn, would buy that person insurance and request payment unless his income was below \$2,000. Under Carter-Long, workers who lose their jobs lose their employee health-plan coverage after ninety days, leaving them the choice of going on welfare, paying as much as \$1,590 for private major-medical insurance or having no coverage.

This situation would not arise under the Kennedy plan, for no one would be refused medical services, no matter how minor his ailment. And since the U.S. Government has the best track record in the world — better than hospitals, doctors or collection agencies — for recovering money, there would be no bad debts. The American Hospital Association estimates that \$9 billion is lost in bad debts to hospitals and doctors each year, and this does not include attorneys' fees and court costs, expenses

that the taxpayer ultimately pays, along with the debt, since financial loss is always calculated into premiums, hospital bills and doctor bills.

According to President Carter's own actuary, Gordon Trapnell of Gordon Trapnell Associates, the Kennedy plan would cost each taxpayer about \$330 a year, including about \$24.6 billion from tax revenues, \$11.5 billion from employers and \$3 billion, from employees and the self-employed (but would save them \$24 billion which they now spend out of their own pockets for health costs as a result of deductibles and coinsurance). Kennedy's actuaries, who included Isidore Falk, Professor Emeritus of Public Health at Yale University, formerly chief of research and statistics for the Social Security Administration and author of the original Social Security legislation passed under Franklin D. Roosevelt, and Rashi Fein, professor of Medical Economics at Harvard Medical School, claim that Trapnell did not take account of all the cost controls in the Kennedy plan; consequently, they insist that each of the above figures would be reduced by a half — making a total almost exactly the same as Trapnell's estimate of \$24.6 billion for the broadly useless Carter-Long plan. But more important, say the Kennedy people, the failure to build cost controls into Carter-Long means steeply rising costs in future years, whereas the Kennedy plan guarantees that medical costs will stay within the pattern of national costs, instead of, as now, rising one and a half times as fast. Indeed, after the initial costs of the Kennedy plan are met, it can be expected within four years to cost less than we are now spending and less than any proposals currently before Congress — while giving everybody more care.

The protest heard at the back of the room is the usual response of the American Medical Association to talk of the Federal Government "monitoring" or "regulating" or "reviewing" the practice of medicine. In fact, Government monitoring is already going on. Since 1972 the Feds have been reviewing both the amounts being paid for treatment and the quality of the care received by Medicaid and Medicare patients in hospitals. Under Carter-Long that would continue, the review of all other care being left, as now, to the discretion of the insurance companies, who without Government imperatives have mainly been content to pay the bills, with no questions asked.

Indeed, our spiraling medical inflation is the direct result of what is known as "cost reimbursement," under which hospitals are paid for their costs retrospectively, with virtually no limit placed on the amount of money they may spend each year. This system, first introduced by Blue Cross in the early 1950s, was extended to Medicare and Medicaid reimbursement formulas in 1965 by Congress with the A.M.A.'s backing. Because paying hospital bills was a whole new experience for Congress, it deferred to the American Hospital Association, while trust-

ing administrators to respect the public treasury. With Medicaid and Medicare funds newly available, hospital administrators, even (and especially) the best, simply stopped denying internal requests for higher wages or more supplies or extra research money or better furniture. Now that the public treasury was available, why worry? The current regulations have the Government and the insurance companies treating hospitals like the doting parent who tells the son he's packing off to college: "Let me know your expenses at the end of the year and I'll pay you back." Under Kennedy's insurance system, the Government would say to Columbia-Presbyterian Hospital, for example, "Here's \$2 million — and that's all you get for the whole year."

Instead of devising more economical means of payment, the profession has been content to let much of the population believe that providing free care or medical insurance to the elderly and the indigent has sent medical costs soaring. Says Herbert Klarman, professor of economics at the Graduate School of Public Administration of New York University, "Federal predictions about utilization increases among the elderly with the passage of Medicare were right on target. They increased by 5 percent. But they didn't expect hospital administrators to turn into greedy children once Uncle Sam became a customer."

The alternatives? We can continue with "cost-based reimbursement" contracts — as would Carter-Long — and watch more hospitals close, more corners be cut everywhere, as the Government, angered at the unabashed greed at its trough, cries out its threats to put a lid on payments for the care of Medicaid and Medicare patients. But the private sector would still be there for the plucking, especially as hospitals would seek to take from private patients what they would lose in Government money. Or we can put hospitals on a yearly budget — as would the Kennedy Health Care For All Americans Act, and subject them to monitoring to prevent corner-cutting.

Under the Kennedy plan, the monitoring would be done by review bodies appointed by a bipartisan national health board and similar state health boards (and consisting of representatives of employers, labor unions, insurance carriers, consumers, physicians and hospitals), which would systematically oversee the work being done in hospitals and in doctors' offices. Death and complication rates for different operations at different hospitals would be made public, not to interfere with the doctor-patient relationship but to provide patients with the information they need to pick a physician rationally. Every doctor giving care in and out of hospitals would have to submit a claim to be reimbursed. These coded claim forms, properly designed, could provide data from which to study the progression of diseases and how they respond to treatment. And by ridding the system of bad and injurious care unnecessarily given, we not only benefit every

QUESTIONS

- *Compare and contrast the major points of the Carter and Kennedy proposals. What are the best ideas of each? Which do you think would have been the more effective plan? Why? What happened to both plans? What impact did A.M.A. lobbying have on their fates? Compare and contrast its tactics in 1979 to those it employed against group health insurance in the 1930s.*

potential patient, we also lower costs.

Thus, for the first time, claim forms which are now filled-out in abundance for reimbursement only would also be used to monitor the effectiveness of the care they record. Privacy would be guaranteed through elaborate coding devices; the claim forms would contain no more private information than now goes to insurance companies and employers anyway, with the difference that employers would no longer receive the forms.

If the Kennedy proposal would not cost more than the Carter-Long plan, would better insure and insure better care, and pose no greater threat to privacy, why such resistance to it? Is it simply because, as labor's George Meany says, the medical establishment has managed through its \$200 billion lobbying campaign to convince the taxpayer that passage of all-inclusive national health insurance will result in costs going through the ceiling and crowds of impatient patients in every doctor's office.

Precisely, says Dr. Falk: "For the last fifty years the A.M.A. has used cost scare tactics to camouflage what the national health insurance debate is really all about: who will control the doctors." In 1932, Falk points out, a national committee on the costs of medical care wrote:

The problem of providing satisfactory medical service to all the people of the United States at costs which they can meet is a pressing one. At the present time, many persons do not receive service which is adequate either in quantity or quality, and the costs of service are inequably distributed. The result is a tremendous amount of preventable physical pain and mental anguish, needless deaths, economic inefficiency and social waste. Furthermore, these conditions are...largely unnecessary. The United States has the economic resources, the organizing ability, and the technical experience to solve this problem.

"The doctors have had fifty years to clean up their act and have failed to do so," says Falk. "Witness the \$100 billion lost last year to bad medical care. That kind of money could supply good medical care to an awful lot of people." The Carter-Long plan would leave the quality of physicians' work virtually uncontrolled, whereas Kennedy's health plan would rigorously monitor the quality of all care. The decisive advantages of the Kennedy plan over Carter-Long should be obvious, but at present Congress is leaning toward the latter. Members of the forgotten middle class should do some leaning of their own — on their Congressmen, for the Kennedy plan.

December 13, 1993:

Hillary & Bill & Harry & Louise

“I know you’ve all seen the ads. You know, the kind of homey kitchen ads where you’ve got the couple sitting there talking about how the President’s plan is going to take away choice and the President’s plan is going to narrow options, and then that sort of heartfelt sigh by that woman at the end, ‘There must be a better way’ — you know, you’ve seen that, right?”

“What you don’t get told in the ad is that it is paid for by insurance companies It is time for you and for every American to stand up and say to the insurance industry: ‘Enough is enough, we want our health care system back!’”

What Hillary Rodham Clinton was referring to in a recent speech was a series of soap opera-style TV ads featuring a woeful couple, “Harry and Louise,” and sponsored by the Health Insurance Association of America (H.I.A.A.). The First Lady positioned herself as a foe of big business; the media played right along.

Tom Brokaw introduced NBC’s segment saying, “Hillary Rodham Clinton today launched a scathing attack on the health insurance industry.” Correspondent Andrea Mitchell, working on the basis of anonymous sources, suggested that the Administration went after H.I.A.A. because “the White House wanted a scapegoat.” On CNN reporters relayed that the Administration is “engaged in something close to an all-out war with the health insurance industry,” and that “the White House would rather talk about insurance industry profits than the rosy assumptions on which its own plan is based.”

A closer look, however, reveals a different sort of deceit on the part of the Administration, the TV networks and Senator Edward Kennedy, who joined in the First Lady’s pseudo-populism, asking the H.I.A.A. to “drop the ads and come work with us” on the Clinton health plan. That plan, in fact, serves the interests of the insurance establishment. As Patrick Woodall of Public Citizen says, “The managed competition-style plan the Clintons have chosen virtually guarantees that the five largest health insurance companies — Aetna, Prudential, Met Life, Cigna and The Travelers — will run the show in the health care system.”

These big companies helped develop Clinton’s plan of managed competition, and all but The Travelers paid for much of the research that was done by the Jackson Hole Group, an organization that drew up the original blueprint for managed competition. (The Administration tries to obscure this; in rebuttal to the H.I.A.A.’s ads, the Democratic Party made a commercial saying of the Clinton plan: “The insurance companies may not like it, but the President didn’t design it for them — he designed it for you.”)

QUESTIONS

- *How did the Clinton Administration organize its efforts to reform healthcare? What were its final proposals? Compare them to previous reform efforts and to the British and Soviet system. Who opposed the Clinton Administration's plans? Why? Did the opponents have a legitimate argument in your opinion? Why or why not? What happened to the Clinton plan?*
- *Try and locate either a copy or a transcript of the Harry and Louise commercial. Why was it so effective? What is at the root of its appeal? Write a commercial that counters Harry and Louise.*

Robert Dreyfuss of Physicians for a National Health Program says, "The Clintons are getting away with murder by portraying themselves as opponents of the insurance industry. It's only the small fry that oppose their plan. Under any managed competition scheme, the small ones will be pushed out of the market very quickly."

Indeed, the H.I.A.A. is made up mostly of small and medium-sized insurers. The five biggest insurers have formed their own organization, the Alliance for Managed Competition, which basically backs the Clinton approach. These big insurers stand to gain from the Clinton plan's increased corporatization of health care since they have been rapidly buying H.M.O.s, 45 percent of which are now owned by the eight largest insurance companies. The outlays for advertisements by the big insurers and the H.M.O.s dwarf the moneys being spent on advocacy ads by the H.I.A.A. and either the Democratic or Republican Party.

The compelling question, then, is not who's behind "Harry and Louise" but who's behind Bill and Hillary?

May 16, 1994:

The Managed Care Scam

By Suzanne Gordon and Judith Shindul-Rothschild

When Ruth Trotman talks about her daughter Robin's condition she can barely contain her despair. Her 19-year-old is suicidal because of a very rare and difficult-to-treat mental illness — obsessive-compulsive disorder (O.C.D.). Robin is terrified of germs and washes her hands until they are raw; she is often so fearful that her mother cannot even leave her side, and she is totally consumed by thoughts about God and His punishment.

Unfortunately, Robin also suffers from a new health care disorder — managed care. She is insured by Bay State Health Care, one of Massachusetts' biggest managed care companies. When trying to lure subscribers, Bay State says that patients will have "thousands of physicians to choose from." Trotman says Bay State told her Robin could be treated out of its network of providers and hospitals if it was medically necessary. Although there seems to be no dispute about the fact that Trotman's daughter needs hospitalization, there is intense disagreement about where. Bay State refuses to allow her to be hospitalized at McLean's, a prestigious psychiatric facility that has the only O.C.D. in-patient unit in the state. Instead, Bay State insists Robin be hospitalized at Fuller Memorial Hospital — a small community hospital in Attleboro that lacks such a specialized program.

Fuller does have one distinct advantage — to Bay State, that is — to attract a managed care contract in psychiatry it provides discounted services to Bay State. Despite Trotman's efforts, including a lengthy appeal through Bay State internal channels, contacts with an attorney and her political representatives, the insurance company has not budged.

"There are nights when I stay up cradling Robin in my arms because she can't stop crying," the anguished mother recounts. "She says she can't stand to go on living this way. What's so terrible is that here's help for her and Bay State won't let her get it. No one can cure her, but they can help her to live with O.C.D."

While Ruth Trotman was trying to save her daughter's life, another Massachusetts woman was trying to deal with a less critical but still troublesome health problem — an immobilizing tendinitis in her right shoulder. She went to an orthopedic specialist, who recommended a course of anti-inflammatory drugs and physical therapy. The woman's insurance company required her to get prior authorization for physical therapy, so she called the number indicated and reached a nurse sitting behind a video display terminal in Washington, D.C. The nurse informed her that her insurer would not allow her to make a physical therapy appointment before she finished a two-week course of anti-inflammatories. When the woman reminded the nurse that she was only following her doctor's orders, the nurse responded, "This is company policy."

When the woman arrived in the physical therapist's office after the two-week drug course, the clinician was shocked at the state of her arm. "Why have you waited so long to come to me?" she said. "You should have come much sooner."

Then there's the case of the elderly California woman dying of multiple myeloma — a cancer of the bone marrow. She had been seeing an oncologist before her health plan switched to managed care. Once that happened, she was told she had to pick a primary care physician from an approved list who would then refer her to an oncologist approved by the plan. Her new primary care physician agreed to allow her to continue with her oncologist, who was not part of the plan, but only on one condition: Before each oncology visit she had to appear at his office to be handed a signed permission slip to see the specialist. The primary care physician billed the health management organization \$85 for each slip. This went on for three months, until the woman became eligible for Medicare. "To have to deal with fighting for care while you're dying is cruel," she said.

Such experiences are becoming the norm in American health care. President Clinton's American Health Security Act may be in trouble in Congress, but its grounding philosophy — managed competition and managed care — is alive and well. Representative Jim Cooper's bill and all the Republican health care proposals endorse managed care's central tenets — that

the way to cut costs is to discipline patients and give insurance companies the responsibility for policing medical practice and patient behavior. Most important, managed care has become the darling of employers, who believe it will save them money. As *Barrons's* recently put it, “employers are already switching en masse from traditional insurance plans to ‘managed care.’”

Americans traditionally equate access to health insurance with access to health care providers and reimbursement for their treatments and services. With managed care — a byzantine system in which insurers and employers herd patients and families into health maintenance organizations (H.M.O.s) or networks of approved physicians and other providers and hospitals, all competing against one another to provide the cheapest services — this equation can no longer be taken for granted.

Managed care does not guarantee access to health care. It merely assures access to what we call “the denial game.” This is an elaborately choreographed dance of come-hither advertising designed to attract subscribers, followed by a series of rules and rejections that get in the way when a patient actually seeks services. The main goal of the denial game is to maintain the profitability of some of the most lucrative corporations in America today — for-profit H.M.O.s and managed care companies that earn profits of up to 20 percent annually. They achieve this goal by three primary mechanisms:

§ The denial of free choice of doctor and hospital and the substitution of a select group of providers who are generally chosen by the criteria of cost and their willingness to follow a managed care plan’s guidelines on which services are appropriate and when.

§ The erection of rigid barriers to access, which are applied to all enrollees regardless of how much or how little they may, in fact, use the system.

§ The bureaucratic micromanagement of care by a group of what we call “invisible diagnosticians” — nurses and physicians who never examine patients but nonetheless decide the course of their treatment.

Consider the impact of the first principle — the denial of choice. The requirement that patients may go only to members of a closed panel of primary care physicians or specialists, the bedrock of managed care, pits clinician against clinician to discount services.

Here’s how it works: Every year physicians on the panel get a report card that grades them according to how much they saved or cost the managed care company in providing patient care. If your primary care physician or specialist is at the top of the list — spending more money than his or her peers on patient care or advocating too aggressively for patients — that doctor will be dropped from the panel and you’ll have to switch to a more “cost-effective” or more tractable provider. Provider

report cards are not based on quality indicators, like complications, re-admissions, suicide or mortality rates. Clinicians are judged solely by their contribution to the corporate bottom-line.

In their effort to obtain cut-rate care, managed care plans also negotiate deep discounts with hospitals. Because managed care groups seek to negotiate the least costly services from year to year, subscribers may be forced to change physicians, nurses and hospitals frequently. Last fall in Massachusetts, Pilgrim Health Care decided to end its \$10 million managed care contract with Tufts New England Medical Center and informed patients they would have to switch to another hospital. After eight years, Harvard Community Health Plan declined to renew its pediatrics contract with Massachusetts General Hospital and instead diverted its patients to Children's Hospital.

This kind of hospital and clinician hopping encourages discontinuities of care. "Competition addicts think that health care is a machine assembled with interchangeable parts. They're wrong," says Alan Sager of Boston University School of Public Health's Access and Affordability Monitoring Project. "Health care is an ecology, in which different organisms often have symbiotic relationships with one another. The patient-clinician relationship is dangerous to uproot, and hard to re-establish. Market forces act like tornadoes, destructively tossing around hospitals, their patients and their staff."

These restrictive policies not only inhibit patients, they severely restrict providers. A prominent Boston physician explained that "if a patient of mine needs a particularly tricky operation, I know there are three or four excellent surgeons in town to whom I can refer the patient. But many insurance companies now force me to refer the patient to surgeons that I know may botch the job."

Physicians and nurses who want to prescribe a particular drug or treatment may not be able to do so because their patient's managed care company will pay for drug A but not drug B. "I had a kid with recurrent ear infections, so I prescribed a stronger antibiotic at the bottom of the H.M.O.'s list, which happened to be the most expensive," one frustrated physician said. "The next thing I knew, the mother of the patient is calling me from home saying that some anonymous reviewer from the H.M.O. — who had never laid eyes on the kid — called and told her I should have prescribed the cheaper antibiotic. She was told that if she wanted the one I prescribed, she would have to pay for it herself. So I have to fight with the insurer to get the kid the medicine he needs. What an incredible waste of time. Just give me the list of the least expensive drugs and I'll prescribe them when appropriate. Don't second-guess my clinical judgment."

Limiting choice — and thus real quality competition among providers — is only the beginning of the denial game.

Next comes restricting the availability of this narrowed range of providers.

One common technique is to decrease staffing levels and increase patient load. Large H.M.O.s tend to keep physician staffing to a minimum, employing one physician for every 800 enrollees (compared with a ratio of about 1:400 in traditional fee-for-service practices). The Kaiser Permanente Foundation Health Plan is one of the most respected H.M.O.s in the country. But following industry trends, it is dramatically increasing physicians' caseloads. For example, in the Sacramento region Kaiser is now adding patients to internists' and family practitioners' caseloads, in some instances increasing the ratio up to 2,700 patients per doctor.

"What is very worrisome in H.M.O.s and managed care plans are the very subtle barriers to even primary care," says Dr. Steffi Woolhandler, assistant professor of medicine at Harvard Medical School and one of the founders of Physicians for a National Health Program. "There are often long waits before appointments; people can't get to see their own primary care physician and have to talk to someone else on the phone. Patients are forced into big practices, where the person they talk to on the phone today may not be the same person they explained their problem to yesterday. When they get to see a provider, they may have only a limited amount of time to outline their complaints."

Other features of most insurance plans today include requirement of prior notification before using emergency room services and the use of the primary care physician as a gatekeeper who will curb unnecessary use of specialist care. The first referral to a specialist may be only the beginning of an unnecessarily complex and costly process that ends up harassing patients, as the dying woman in California so rudely discovered. Often patients become so tired of going through managed care hoops that they forgo needed treatment or pay for specialist or other services out of pocket.

The roadblocks to care for the supposedly well insured are assiduously patrolled by a new cadre of health care personnel — the care police — who often receive more money for denying needed care than nurses and doctors who are actually delivering care at the bedside. Insurance company executives insist that these "utilization reviewers", as they are euphemistically dubbed, are only making sure that providers follow accepted standards of care and that patients don't "overuse the system." In fact, they are diagnosing and treating patients without ever setting eyes on them.

Pam Calarese, an oncology nurse at Norwood Hospital in Norwood, Massachusetts, and the nurse manager of its outpatient oncology-hematology department, describes what is now becoming routine practice. She recently had a patient with head

and neck cancer. Physicians ordered a standard protocol, which includes doses of a chemical, cisplatin. Cisplatin is highly toxic to the kidneys. If the dose is too high and/or, if patients do not receive sufficient hydration, they can go into renal failure.

When the patient's oncologist called his insurance company to get authorization for the treatment, the anonymous physician at the other end of the line informed him that they would approve payment only under one condition — that the patient be given a dose of cisplatin five times stronger than that recommended in the protocol.

“To say that we were shocked is an understatement, said Calarese. “If we did that we would have killed the patient, which is just what the doctor and the nurses at the clinic told the insurer. But they insisted. The doctor refused and they backed down.”

In managed care plans, the physician or nurse harassing other doctors or nurses is not required to see the patient whose clinical needs this individual is assessing and whose future is being determined. Utilization review physicians and nurses sometimes have no specialty training in the field they are evaluating. Even more frightening, many utilization reviewers are not even health care professionals. Their names are not written into the patient chart. Most important, they cannot be sued or otherwise held accountable for their decisions.

“We have a structure for providing medical care in this country. What insurers have created is a shadow structure,” says Woolhandler. “For every action a physician or nurse takes, there is a paper construction reflecting it and a person reviewing it. Everything is done twice — by me and by my shadow. These shadows follow computer protocols that are kept secret. They won't tell us why they are denying needed care, they just say the protocol says no. If I see a patient who I think has a retinal detachment that can lead to blindness, and I say she needs to see an ophthalmologist, and the shadow says no she doesn't, that shadow is not legally liable. But I am. These people are entirely out of the loop of accountability and quality.”

The role of these new, invisible diagnosticians makes a mockery of managed care advocates' rhetorical pronouncements about quality care, consumer choice and the potential of consumer education — all touted features of the Clinton plan. How can patients and families learn how to navigate a health care system in which the real decision-makers are completely insulated from public scrutiny and patient criticism? What good is consumer information about a hospital or physician or other provider, when neither that institution nor that individual provider is really the one pulling the most important health care levers? What good does it do to increase the number of primary care providers, if those providers are simply viewed as servants of managed care companies?

QUESTIONS

- *What is managed care? Why is it a “scam,” according to the authors? Why do health care companies favor managed care? Do additional research to find out the impact of managed care. Does it benefit consumers? Has it improved health care in the United States? List the major health care providers in the U.S. Find out how profitable managed care has been for those companies in the years since this article was written.*
- *Create what you think would be the best national healthcare system. Explain your choice and use statistics to back up your arguments. What do you foresee happening for the nation’s healthcare in the next ten years? Explain.*

The final irony of managed care is that it raises, rather than lowers, health care costs, as studies by numerous government agencies and health care researchers have shown. Managed care groups have higher administrative overhead than did Medicare or traditional indemnity plans like Blue Cross ten or twenty years ago. Managed care companies spend huge sums on advertising and marketing, and on paying utilization reviewers to micromanage each case. In order to amass the profits necessary to pay executive salaries in the seven figures, enrich stockholders and offer bonuses to elite physician providers — some of whom now receive year-end perks based on the amount of care and treatment they denied — managed care companies must cut labor costs, increase provider productivity by enforcing assembly-line conditions and skimp on the care and treatment they make available to patients.

Over and over Washington politicians insist that Americans must be willing to make sacrifices and tough choices to solve the nation’s health crisis. But it is politicians, not patients and their families, who need to make them. Our health care crisis will be solved only when government leaders are willing to set global budgets, negotiate fee scales for physicians, rein in drug company costs and fairly and democratically ration expensive medical technology, as is done in every other industrialized country. Not surprisingly, politicians, who would rather avoid the accountability for such tough decisions, are attracted to a free-market approach (not to mention free-market dollars). But substituting the invisible hand of the market for the visible courage of political leadership is the wrong prescription.

Study after study — as well as the experience of governments in Europe and Canada — has documented that a single-payer financial reimbursement mechanism is the only way to save money and increase access while maintaining quality and continuity of care. As patients are learning every day, managed care, on the other hand, does little but manage the care right out of our health system.

Managing Pools

By Patrick Woodall and Nancy Watzman

With the health care reform debate finally in full swing on Capitol Hill, managed care companies are joining in the lobbying fray along with the doctors, hospitals and other special interest groups. An analysis of disclosure forms filed by the top ten companies, as measured by enrollment, and their two main trade associations shows that they have hired a phalanx of Washington insiders.

In 1993, managed care companies, which include the Alli-

ance for Managed Competition's Aetna, MetLife, CIGNA, Prudential and The Travelers, as well as Humana and Blue Cross/Blue Shield, spent upward of \$659,000 on lobbying activities.

These companies also pump in campaign contributions. Six of their PACs alone have given \$1,642,562 since 1991, according to figures compiled by the Center for Responsive Politics for *The Wall Street Journal*. In 1993, MetLife's employee PAC gave \$95,150 and Prudential gave \$80,491 to members of Congress. Some of the leading recipients of health industry cash are Representative Dan Rostenkowski and Senator John Chafee. Although Representative Jim Cooper, sponsor of a conservative managed competition plan, doesn't take PAC money, he accepted \$13,500 in individual contributions from twenty-one associates of PacifiCare, according to Citizen Action, a national consumer group. He's taken a total of \$196,600 from people associated with health and insurance interests.

There's a certain irony in all this effort, since managed care companies are the most likely of the various health care interests to make out well in whatever bill emerges. The H.M.O. managed care model is the inspiration for two of the biggest contenders in the health care stakes — the Clinton bill and Cooper's business-backed alternative. And while some of the other proposals may not make managed care the basis for reform, they don't do anything to crack down on these companies, either.

How is it that these companies are so well positioned politically? Back in the late 1980s, when no one in Washington was taking health care reform particularly seriously, groups of health industry C.E.O.s, health economists and lawmakers were already gathering in a posh ski resort in Jackson Hole, Wyoming. Among the companies attending regularly were Aetna, CIGNA, Prudential and MetLife. Feeling squeezed between the spiraling costs of health care prescribed by doctors and the demand from consumers, these companies were trying to find ways to control costs while keeping profits high. At these cozy gatherings, much of the philosophy of managed competition was constructed. When presidential candidate Bill Clinton emerged as a real contender for office, managed competition proved a perfect vehicle for his health care philosophy.

Even as managed care companies are doing their best to secure future growth through government action, they are already taking over the market at an alarming rate. A recent study by Marion Merrell Dow found that the ten largest firms (Aetna, Blue Cross, CIGNA, HIP of Greater New York, Humana, Kaiser Permanente, MetLife, Prudential, United Healthcare and U. S. Healthcare) own 266 of the 421 H.M.O.s in the country, or 63 percent, covering more than 25 million people, or about 70 percent of the managed health care market.

The managed care industry has also been remarkably

QUESTIONS

- *How much money have the major managed care companies spent on lobbying and political campaigns through their PACs since this article was written? Identify the major healthcare votes in Congress over the past four years. How did your Representatives and Senators vote on those bills? How much money, if any, did they take from managed care companies?*

lucrative. CIGNA made \$234 million in profits in 1993; its managed care business continued to be its strongest performer and is expected to gross \$410 million in 1994. U.S. Healthcare made \$299 million in profits in 1993, up 50 percent from 1992. United HealthCare posted similarly successful results for 1993, earning \$194 million in profits, up 55 percent from 1992. The Travelers' managed care products grossed \$3.6 billion in 1992 — about 37 percent of its revenues — and is the fastest-growing sector of its business.

Corporate executives are paying themselves well. CIGNA's president, C.E.O. and chairman of the board Wilson Taylor had a salary of \$2.39 million in 1993, and Lawrence English, division president, made \$1.17 million. PacifiCare's C.E.O., Terry Hartshorn, made \$1.22 million in 1993 and held 220,000 shares of PacifiCare stock. Humana C.E.O. David Jones made a comparatively low \$741,741 in 1993, but paid \$53 million to buy almost 6 million shares of Humana's stock, tripling his stake in the company. Leonard Abramson, C.E.O. of U.S. Healthcare, made \$3.24 million.

In 1992, an index of sixteen H.M.O. stocks showed an 80 percent gain, with certain individual issues almost tripling in price, according to the investment firm Furman Selz. From 1987 to 1992 the value of PacifiCare's stock increased by more than 3,000 percent, with United HealthCare following at a 2,789 percent increase. CIGNA's earnings are up dramatically from 1992, from \$3 a share to \$5.25.