

# Private Health Insurance

## Part One†

### CHANGING PATTERNS OF MEDICAL CARE DEMAND AND SUPPLY IN RELATION TO HEALTH INSURANCE

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The growth of private health insurance in the United States has been phenomenal. As recently as 1940 less than 10 per cent of Americans had any hospital insurance, only 4 per cent had some surgical coverage and slightly over 2 per cent any form of non-surgical medical insurance. By the end of 1957, the percentages were roughly 71, 64, and 42 respectively.<sup>1</sup> Between 1948 and 1956 annual premium payments increased four-fold, from less than \$0.9 billion to over \$3.6 billion. (See Table I.)

TABLE I  
Private Expenditures for Medical Care and Voluntary Health Insurance,  
Selected Years

	Expenditure				
	1948	1951	1954	1955	1956
	Amount (in millions)				
Total .....	\$7,300	\$8,715	\$10,491	\$11,209	\$12,091
Direct Payments .....	6,438	7,055	7,735	8,059	8,467
Insurance Benefits .....	606	1,353	2,179	2,536	3,015
Expenses for Prepayment <sup>a</sup> .....	256	307	577	614	609

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<sup>1</sup> According to the Health Insurance Council, over 121 million were protected against hospital costs, 109 million against surgical costs and 72 million against other forms of medical expense. Press Release, June 12, 1958. Percentages computed against the Census estimate of U.S. civilian population, Nov. 1, 1957, of 170 million (excludes armed forces). U.S. BUREAU OF THE CENSUS, DEPT. OF COMMERCE, Ser. P-25, No. 169 (1957). Enrollment data is published annually in HEALTH INSURANCE COUNCIL, THE EXTENT OF VOLUNTARY HEALTH INSURANCE COVERAGE IN THE U.S. Unless otherwise noted, all enrollment data in this paper are from this source.

Percentage Distribution					
Total .....	100.0	100.0	100.0	100.0	100.0
Direct Payments .....	88.2	81.0	73.7	71.9	70.0
Insurance Benefits .....	8.3	15.5	20.8	22.6	24.9
Expenses for Prepayment .....	3.5	3.5	5.5	5.5	5.1
Hospital Services <sup>b</sup> .....	25.4	28.4	32.3	33.1	33.9
Direct Payments .....	16.6	16.0	15.4	15.1	14.3
Insurance Benefits .....	6.2	10.3	13.8	15.0	16.7
Expenses for Prepayment .....	2.6	2.1	3.1	3.0	2.9
Physicians' Services <sup>b</sup> .....	31.5	30.8	30.6	30.3	29.9
Direct Payments .....	28.5	24.2	21.2	20.2	19.5
Insurance Benefits .....	2.1	5.2	7.0	7.6	8.2
Expenses for Prepayment .....	.9	1.4	2.4	2.5	2.2
Medicines and Appliances .....	24.5	23.5	20.9	20.7	20.7
Dentists .....	11.4	10.2	9.3	9.1	8.8
All other .....	7.2	7.1	6.9	6.8	6.7

<sup>a</sup> Represents difference between expenditures for health insurance premiums and amounts returned to consumers as benefits.

<sup>b</sup> Combines amounts received by providers of service (direct payments and insurance benefits) and the costs of financing prepayment.

Source: Derived from Social Security Bull., Dec. 1957, p. 4, Table 1. Footnotes omitted or abbreviated.

This development<sup>2</sup> had its origin in the Depression but the greatest impetus came during the period when Americans were politically embroiled in debate over proposals for national compulsory health insurance and Californians were disputing the Olson and Warren proposals for a similar state program. Private health insurance plans were rapidly advanced as alternatives to governmental programs. Equally important was the simultaneous growth of organized labor and collective bargaining. The wartime wage stabilization program and its encouragement of "fringe benefits," the effect of National Labor Relations Board and U.S. Supreme Court decisions in making such benefits a routine matter for collective bargaining, management's increasing concern for "human relations" in industry, and the con-

<sup>2</sup> The voluminous literature on the development of voluntary health insurance in America includes only a few works of enduring value. Among the more useful to the non-specialist are: GOLDMANN, VOLUNTARY MEDICAL CARE INSURANCE IN THE U.S. (1948); *Health Insurance Plans in the U.S. (Clark Report)*, S. REP. NO. 359, 82d Cong., 1st Sess. (1951); 4 PRESIDENT'S COMMISSION ON THE HEALTH NEEDS OF THE NATION, BUILDING AMERICA'S HEALTH (1952-53) (hereinafter cited as BUILDING AMERICA'S HEALTH); SERBEIN, PAYING FOR MEDICAL CARE IN THE U.S. (1953); CHAMBER OF COMMERCE OF THE U.S., A LOOK AT MODERN HEALTH INSURANCE (1954); *Health Inquiry, Hearings Before the House Committee on Interstate & Foreign Commerce*, 83d Cong., 2d Sess., pts. 6-7 (1954); O. W. ANDERSON & J. J. FELDMAN, FAMILY MEDICAL COSTS AND VOLUNTARY HEALTH INSURANCE: A NATIONWIDE SURVEY (1956).

tinuing post-war emphasis on "health and welfare plans"<sup>3</sup> all helped to accelerate the growth of voluntary health insurance.<sup>4</sup>

This marriage of medical care and industrial relations has had a decisive influence upon the growth and character of health insurance and other medical institutions. The vast majority of insured persons and perhaps three-fifths of all Americans owe their health insurance to an employee benefit plan,<sup>5</sup> paid for in full or in part by their employers,<sup>6</sup> who are now contributing about \$1 billion a year.<sup>7</sup>

Health insurance, once a controversial issue, is now a fully accepted instrument for dealing with medical costs. Its achievements are impressive. Yet, there remains considerable controversy as to whether the voluntary mechanism will prove adequate to the need. A deep sense of uncertainty pervades the atmosphere and frequently erupts into conflict even among those who appear to have prospered most from recent developments. Professional and trade journals bristle with accusations and suspicion. Doctors

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<sup>3</sup> This vague term covers a package of employee benefits, either negotiated through collective bargaining or unilaterally granted by the employer. Usually included are group life and accident insurance; sick pay, disability insurance or other form of reimbursement for wages lost due to non-occupational accident or illness; and hospitalization, surgical and other medical benefits. Pension plans, holiday pay and similar forms of employee benefits are excluded from the usual definition. See, for example, U.S. BUREAU OF LABOR STATISTICS, DEPT. OF LABOR, BULL. NO. 1221, *HEALTH AND INSURANCE PLANS UNDER COLLECTIVE BARGAINING, LATE 1955* 1 (1957). The stricter definition of the Division of Labor Statistics and Research, Calif. Dept. of Industrial Relations, will not list a plan as "health and welfare" unless some provision for prepayment of medical care is included. Industrial Relations Reports, May 1957, p. 3. In any case, medical care benefits are so prevalent and account for so large a part of total health and welfare funds that, in the parlance of industrial relations, the two are often synonymous.

<sup>4</sup> "Voluntary health insurance" is here used interchangeably with private health insurance, in accord with common usage.

<sup>5</sup> The Senate Committee on Labor and Public Welfare estimated that, in 1954, nearly 76 million workers and their dependants—about half the population—were covered by some form of health insurance provided through health and welfare plans. *Welfare & Pension Plans Investigation*, S. REP. NO. 1734, 84th Cong., 2d Sess. 82 (1956). Since then the number of group health insurance enrollees has continued to increase both absolutely and in relation to those covered by individual policies.

<sup>6</sup> The 1955 Bureau of Labor Statistics study (see note 3 *supra*) of 300 large health and welfare plans, each covering 1,000 or more workers, found that slightly more than half the plans, covering a little less than half the workers, provided for full payment by the employer (Table A-3, *Id.* at 5). In California, in Jan. 1957, nearly 90% of all workers covered by negotiated plans had the full cost paid by their employer. Div. of Statistics and Research, Calif. Dept. of Industrial Relations, Industrial Relations Reports, May 1957, p. 4. The difference between the California and national data may be explained, in part, by the difference in time and by the greater prevalence of multi-employer units on the West Coast.

<sup>7</sup> The Senate Committee estimated that employers contributed, in 1954, \$652 million. S. REP. NO. 1734, 84th Cong., 2d Sess. 84 (1956). For 1955 the amount has been estimated at \$840 million. H. E. Klarman, *Changing Costs of Medical Care and Voluntary Health Insurance*, p. 16 (address to Amer. Econ. Ass'n and Amer. Ass'n of Univ. Teachers of Insurance, Cleveland, 1956 mimeo). The continued rise in premiums during the past two years would easily bring the figure to \$1 billion in 1957.

and insurance executives attack each other, but unite in blaming consumers for alleged abuse of health insurance. Medical societies and hospitals are in combat over the issue of "corporate medicine," the loaded term used to describe salaried practice in hospitals. And some now see in organized labor and its growing influence in medical institutions a threatening ogre comparable to that represented in former years by the federal government. Some of these conflicts are discussed later in this paper.

More thoughtful participants in these developments, however, see beneath the surface tensions and conflicts "certain social, political or economic trends that are almost inexorable."<sup>8</sup> The main purpose of this paper is to identify the most important of these powerful trends and the issues and prospects they pose for the future of voluntary health insurance. To do this, it is essential to examine not only health insurance institutions themselves but also the two underlying factors which condition the character of health insurance: consumer demand for medical care and the technology and organization of its provision or supply.

Health insurance is primarily a financial mechanism for bringing supply and demand into a satisfactory and mutually sustaining relationship. But so large and dynamic an institution cannot be neutral in its own influence upon the nature of demand or the organization of supply, even when its administrators so intend. Health insurance has altered the nature and extent of both the demand and the supply just as surely as the latter have influenced the nature and course of health insurance. The three sets of phenomena, each of which is in a process of rapid transition, are partly mutually interactive in their effect on one another and partly independent. For purposes of analytical clarity they will be dealt with separately. Part One concentrates on the basic supply and demand factors influencing the need for and character of health insurance; Part Two on the problems and prospects of health insurance itself.

While this paper is primarily concerned with voluntary programs, it must be kept in mind that these programs are not the only important mechanism for supplementing direct consumers' expenditures for medical care in the U.S. today. Despite its sensational growth and its near monopoly of the health insurance field,<sup>9</sup> a far larger proportion of the nation's total medical care bill is still financed through public programs than through private health insurance. In 1956, about 30 per cent of total U.S. medical expenditures was financed by government—local, state and national.<sup>10</sup> If

<sup>8</sup> Dr. A. W. Snoke, past president, Amer. Hosp. Ass'n, in *Hospitals—Their Current and Future Problems*, HOSPITALS, Oct. 16, 1957, pp. 41, 44.

<sup>9</sup> Part Two will include a listing of the few existing public health insurance programs.

<sup>10</sup> Total expenditures for health and medical care in 1956 were about \$17 billion. Consumers paid \$8.5 billion directly. Health insurance premiums accounted for \$3.6 billion. Almost \$5 billion was financed through public programs. See Table I and Merriam, *Social Welfare Expenditures in the U.S.*, Social Security Bull., Oct. 1957, pp. 3, 10–11.

the area of comparison is narrowed to personal health services, disregarding public expenditures for military and community health services, the public sector accounts for 21.4 per cent as compared to 18.9 per cent for voluntary health insurance.<sup>11</sup>

Ideally, therefore, a thorough analysis of the private programs should include an examination of public programs, as the two areas are inter-related. Space does not permit. In any event, it is an axiom of American political life that government is generally permitted to do only what private institutions cannot or will not do. It may be reasonably predicted that government participation in the health insurance field will increase only to the extent that the private institutions fail to fulfill the expectations they have helped to create. The nature of these expectations, the extent to which they are being fulfilled under existing health insurance arrangements, and the potentiality for future fulfillment are the main themes to be pursued.

## I

### THE NEW DIMENSIONS OF DEMAND

During the past 20 years, profound changes have taken place with respect to the extent and nature of demand for health services. At the root of these changes is the scientific revolution in medicine.

#### *A. The Scientific Revolution in Medicine*

Scientific, technological, and economic advances have combined to increase the effectiveness of medical care to a point where it is now a decisive factor in personal and national welfare. This is less a truism than might appear at first glance. The essentiality of medical care is a relatively recent phenomenon. A distinguished medical authority put the matter sharply: "I think it was about the year 1910 or 1912 when it became possible to say of the United States that a random patient with a random disease consulting a doctor chosen at random stood better than a fifty-fifty chance of benefiting from the encounter."<sup>12</sup> Today, 50 years later, medicine has penetrated mysteries of the human body and mind and mastered techniques of surgery, chemotherapy and psychiatry which were not dreamed of at the beginning of the century. At a rapidly accelerating pace, the complex of knowledge and skills now embraced under the composite term "medical care" has increasingly gained the power to give or to withhold life, to give or to withhold the functional capacity which may determine the value of life not

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<sup>11</sup> *Id.* at 11.

<sup>12</sup> L. J. Henderson as quoted in GREGG, CHALLENGES TO CONTEMPORARY MEDICINE 13 (1956). Dr. Gregg, who served for many years as chief of the Division of Medical Sciences and vice-president of the Rockefeller Foundation, interprets this statement as meaning, "somewhere about that time the batting average of the generality of doctors had improved to a point where it made sense for one to ask them to go to bat."

only for the seriously disabled but for the great majority of all people who suffer some degree of chronic disability.

This is, of course, not an achievement of the superior wisdom of our century. As Bernard of Chartres put it, the men of any generation are like dwarfs seated on the shoulders of giants. If we are "to see more things than the ancients and things more distant" it is "due neither to the sharpness of our sight, nor the greatness of our stature." But "simply because they have lent us their own." The indispensable foundation for the capacities of contemporary physicians and surgeons traces back to the pioneering inquiries and insights of the early Egyptians and Greeks and the European Renaissance. The discovery of asepsis was no less important and remarkable in its time than the antibiotics and sulfas in ours—and the latter could only follow, not precede, the former. However, as knowledge and skill are cumulative, their expansive force tends to grow geometrically and thus it is that the recent advances in science and technology have made the earlier days of our own century seem like ancient times indeed.

Similarly, it is not possible for medicine to progress or even be meaningful in isolation from the total environment of which it is a part. The achievements of modern medicine stem directly from progress in general scientific research. Engineering advances have been vital to the practical application of scientific medicine. Industrialization, economic progress, social organization, and the spread of humanism and democracy have all contributed to the advance of health and physical well being and the present state of the medical arts. The causal factors explaining the health progress of the nation are multifold, complex, and interdependent. No one knows how much to attribute to medicine as such. But it is clear that medical science is an indispensable ingredient in the amalgam and, even more, that the utility and effectiveness of the other contributing factors such as basic research and improved nutrition find their expression in large part through applied medical arts.

The overall picture of health advance is well known.<sup>13</sup> In the first half of our century the mortality rate declined by almost half. Between 1915 and 1955 alone infant mortality was cut 75 per cent. The ravages of typhoid, diarrhea, dysentery and other infectious diseases have been drastically curtailed. Between 1900 and 1956 the mortality rate from tuberculosis, pneumonia and influenza dropped more than 90 per cent. A baby born in 1957 could be expected to live 23 years longer than one born in 1900.

An even more dramatic comparison, in that it minimizes the nonmedical

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<sup>13</sup> For a convenient summary of health statistics as of 1950, see 3 *BUILDING AMERICA'S HEALTH*. New and dramatic documentation of "Fifty Years of Health Progress" is being accumulated and presented by the Health Information Foundation in its monthly bulletin, *Progress in Health Services*. See, for example, Mar. and Apr. 1957, Jan. and Feb. 1958.

factors, can be made from the records of military death rates: "Where 650 men on the Union side died of disease in the Civil War, there were 250 in the Spanish-American War, 160 in the First World War, and 6 in the Second World War. An improvement of one hundredfold in 90 years."<sup>14</sup>

The evidence as to the increasing effectiveness of modern medicine is vast and incontrovertible. Dr. René Sand, the great Belgian epidemiologist, has said: "We can buy human life. Each country within certain limits decides its own death rate."<sup>15</sup> While the phrase has a probably deliberate melodramatic touch, the essential point is patent: the degree of accessibility or nonaccessibility of modern medical care is now a demonstrably crucial factor in personal and national welfare and is subject to conscious policy influence.

### *B. Medical Care as a Civic Right*

There is today a broad consensus in this country that people should receive the medical care they need. In 1952 The President's Commission on the Health Needs of the Nation, sixteen eminent citizens representing educational, industrial, labor, agricultural, and consumer interests, as well as the various health professions, after a year of study and voluminous testimony, agreed upon a set of guiding principles for approaching the nation's health problem. The first of these was: "Access to the means for the attainment and preservation of health is a basic human right." The Commission also said, "We set as a goal for this Nation a situation in which adequate health personnel, facilities, and organization make comprehensive health services available for all, with a method of financing to make this care universally accessible."<sup>16</sup>

This concept of medical care as a "right" has now become part of our political vocabulary. A 1957 study of tax-supported medical programs in Pennsylvania begins as follows, "Democratic societies are by definition committed to a series of ethical assumptions emphasizing the value of human life and well-being. We interpret these humanitarian principles to mean that each individual has the right to command certain fundamental necessities, among them, medical care."<sup>17</sup>

This new public attitude toward medical care stems partly from the growing health consciousness of the American people, partly from their

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<sup>14</sup>GREGG, CHALLENGES TO CONTEMPORARY MEDICINE 7 (1956).

<sup>15</sup>Quoted in TYTMUSS, PROBLEMS OF SOCIAL POLICY 535 (1950).

<sup>16</sup>1 BUILDING AMERICA'S HEALTH 3.

<sup>17</sup>PENNA. DEPT. WELFARE, SURVEY BY A UNIV. PENNA. FACULTY COMM., TAX-SUPPORTED MEDICAL INSTITUTIONAL CARE FOR THE NEEDY AND MEDICALLY NEEDY 10 (1957). Launching a new series of publications dealing with labor health programs, the AFL-CIO supported American Labor Health Ass'n entitled its first one, YOUR RIGHT TO MEDICAL CARE.

increasing familiarity with the new medical potential.<sup>18</sup> During World War II and the Korean War, for example, the whole vast armory of American medical resources and skills was put at the disposal of the humblest Army private from Mississippi and a whole gamut of free medical services was provided to his dependents. Millions of civilian war workers obtained, for the first time in their lives, access to first-class medical care on a non-charity basis. The trend has, in lesser degree, continued since the war, thanks primarily to the new methods of financing medical care, both public and private. Today, more people are directly experiencing the benefits of the scientific revolution in medicine than ever before.

The new attitude also stems from the changing socio-economic climate of post-war America. It comes from more education, higher incomes and greater mass purchasing power. Knowledge, accompanied by general rising standards of living, brings expectation and demand. People may not take literally Dr. Sand's dictum—"We can buy human life"—but an increasing number of Americans appear to have adopted the view that "adequate medical care" is as much implicit in the right to "life, liberty and the pursuit of happiness" as, for example, public education.

This revolution in individual attitudes is intertwined with new community attitudes. We are continuously reminded that industry and the economy, our productivity, resources, and security suffer conspicuously and often unnecessarily from the losses caused by illness, absenteeism, and disability.<sup>19</sup> In recent years, it has been progressively emphasized that health and medical care are essential sources of military and national strength. And we are equally often reminded that this does not simply rest in the laps of the gods. Little wonder then that medical care is changing from the status of a "private luxury" or a "blessed benevolence" to that of a "civic right."

Equally important, however, is the fact that when Americans speak of "adequate medical care" they do not have in mind any finite or definable quantity or quality. The incoherence and potential enormity of this new

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<sup>18</sup> The success of *The Reader's Digest* and other mass publications in promoting the idea of "Everyman his own doctor" is well known. Less obvious but equally important is the trend within the profession itself to train patients in the early detection of disease and preliminary self-diagnosis. Consider the importance attached to public familiarity with the seven common symptoms of cancer. Woe to the mother today who calls her pediatrician without having first checked her child's temperature! A more extreme example is described in *The New York Times* of May 5, 1957, p. 84: "There is an orthopedic physician in town who would make every man a diagnostician. So intent are he and his hospital associates on the early detection of orthopedic symptoms in the very young that they do not care how many incorrect diagnoses are made by the layman . . . Dr. Joseph Milgram, director of orthopedic surgery at the Hospital for Joint Diseases, and his associates there are talking early detection to teachers, parents, school nurses and to anyone having anything to do with children."

<sup>19</sup> For example, the study, *RESEARCH COUNCIL FOR ECONOMIC SECURITY, PROLONGED ILLNESS ABSENTEEISM* 176 (1957), indicated a national annual loss to industry of 453,000 man years from prolonged illness (at least 4 weeks) alone.



demand, if present economic barriers were removed or reduced, has led some to fear that health insurance could, like the Sorcerer's Apprentice, be almost drowned in the flood which it might unloose without being able to control. For example, Professor Ginzberg has cautioned, "There is a marked difference between society's commitment to provide free education . . . and a commitment to provide adequate medical care for all in need. Education can be quantitatively delimited. Moreover, it requires that the individual exert himself. The limits of medical care are much more elastic. . . ."<sup>20</sup>

There is, however, accumulating evidence that both the extent and nature of the potential demand for medical care are more subject to definition and measurement than was thought possible only a few years ago. Several kinds of studies have greatly increased our knowledge of present and future demand patterns: the public health survey with its emphasis on basic demographic, morbidity, and disability data; studies of medical care expenditures; and of medical care utilization.<sup>21</sup> Together they shed a good deal of light on the possibility of meeting this new demand through voluntary health insurance.

### *C. The Changing Pattern of Basic Needs*

Increasing life expectancy has altered our population picture and this in turn has resulted in marked changes in the incidence and pattern of illness. Four times as many persons in the United States today are 65 or over as in 1900. As a proportion of the total population they have more than doubled: 4.1 per cent in 1900 to 8.6 per cent in 1955. The number of aged and aging will continue to increase rapidly. Based on 1955 death

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<sup>20</sup> Ginzberg, *Health, Medicine, and Economic Welfare*, 19 JOUR. OF THE MOUNT SINAI HOSP. 734, 738 (1953).

<sup>21</sup> The Public Health Service's first National Health Survey (1935-36) included 2.5 million persons in 83 cities. This was followed by several local surveys. A new program of national health surveys, authorized by Congress in 1956, is now under way. 70 STAT. 490 (1956), 42 U.S.C. § 242C (Supp. V, 1957). A major California survey was authorized by the state legislature in 1947. Cal. Stat. 1947, c. 327, CAL. HEALTH & SAFETY CODE §§ 430-35.7. For background and methodology, see CALIF. DEPT. OF PUBLIC HEALTH, HEALTH IN CALIFORNIA 1-10 (prelim. mimeo. 1957). Additional morbidity data is available from Selective Service, state and local health departments, the life insurance industry, the Commission on Chronic Illness, and other agencies, public and private. Annual data on consumer expenditures for medical care is available from the U.S. Dept. of Commerce (July issues of Survey of Current Business) and the Social Security Administration (December issues of Social Security Bull.) and periodic studies by the American Medical Association Bureau of Medical Economics Research. The first major study of family medical expenditures and utilization was made by the Committee on the Costs of Medical Care in the late Twenties. A major contribution is the Health Information Foundation nationwide survey, ANDERSON & FELDMAN, FAMILY MEDICAL COSTS AND VOLUNTARY HEALTH INSURANCE (1956), and its more intensive study of insured families in Boston and Birmingham, ANDERSON AND STAFF OF NATIONAL OPINION RESEARCH CENTER, VOLUNTARY HEALTH INSURANCE IN TWO CITIES (1957). For a bibliography of the growing literature of utilization, see Social Security Admin., Res. & Stat. Note 34, Sept. 1957.

rates, there will be at least 21 million 65 or over by 1975, as compared to 14 million in 1955. How much they will continue to increase relative to the whole population is uncertain and depends mainly on the future birth rate. If this continues at its recent very high level, the increase in the proportion of the aged may be relatively small. On the other hand, a decline in fertility, which appears more likely, would mean a rapid increase in the proportion of the aged. The 1958 estimates of the Social Security Administration indicate a range from 9.4 per cent to 10.7 per cent for 1975 and from 9.7 per cent to 12.9 per cent in 1990.<sup>22</sup> In any case, it appears that by 1975 persons 45 and over will constitute about one-third of the population.

Such demographic changes have been accompanied by marked changes in morbidity patterns but overall illness rates have not declined. Increased longevity means primarily a shift in incidence from disease of the young to diseases of the aging and the reduction in mortality means more illness among the aged. At the beginning of the century, the three leading causes of death were influenza and pneumonia, tuberculosis, and diarrhea and enteritis—all acute infectious diseases which affect primarily the young. By 1950, the three leading causes of death were diseases of the heart, cancer, and vascular lesions of the brain—chronic degenerative diseases associated primarily with older age groups and characterized by insidious inception, long duration and a high proportion of residual disability.

Whereas the incidence of acute illness, including respiratory and other communicable diseases, gastrointestinal disorders, and accidents, is greatest among the young and declines with age, the pattern is reversed for chronic illness.<sup>23</sup> Compared to the population as a whole, those 65 and over experience two to three times as much chronic illness. Persons 45-64 also have a strikingly higher degree of chronic illnesses than young people. The result is that total days of disability increase sharply with advancing age as does the average rate of hospital utilization. The aged average about three times as many days of disability a year<sup>24</sup> and over twice as many days in the hospital<sup>25</sup> as the general population.

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<sup>22</sup> Soc. Sec. Admin., Res. & Stat. Note 15, May 1957. These estimates include the outlying areas of the U.S.

<sup>23</sup> In general a chronic illness is one of a continuing or recurrent character, while an acute one is not. There is general agreement upon the classification of the more common chronic ailments such as cardiovascular diseases, asthma and hay fever, back conditions, arthritis and rheumatism, hypertension, etc. But the precise definition of the boundaries of "chronic illness" is necessarily arbitrary and varies with different sources. The National Health Survey of 1935-36 defined it as any illness where the symptoms had been observed for at least three months. 3 BUILDING AMERICA'S HEALTH 128.

<sup>24</sup> The National Health Survey, counting only illnesses which were disabling for 7 consecutive days or more, reported an average of 36 days of disability per year for those 65 and over as compared to 10 for all ages. *Ibid.* The California Survey, counting all illnesses disabling for one or more days, reports an average of 65 days per year for those 65 years and over, 31 days for those between 45-64, and 24 for the population as a whole. CALIF. DEPT. OF PUBLIC HEALTH, HEALTH IN CALIFORNIA 31 (prelim. mimeo. 1957).

<sup>25</sup> In 1953, the aged averaged 7.1 days of hospital care as compared to 2.9 for the general population. They constituted 20% of all hospitalized persons. About ⅔ were in mental, tuber-

About half of the hospital beds in the country are now occupied by the mentally ill, and more than half of all Veterans Administration hospital patients are psychotics. It is not difficult to understand why mental illness is often called the nation's foremost health problem. On an average day in 1956, 722,000 persons—almost equal to the combined population of Nevada and New Hampshire—were patients in psychiatric hospitals. For a quarter-century there has been a steady and alarming increase in mental illness.<sup>26</sup> In part, this is due to a better understanding and ability to recognize the nature of mental disease and society's relatively new willingness to accept it as such. In part, however, the influence of longevity is evident. The incidence of mental illness is far more pronounced among the aged than in the general population.

It appears clear that a progressively larger proportion of the nation's total demand for medical services will relate to the growing problem areas—chronic and mental illness.<sup>27</sup> The corollary of this shift is an increasing need for long-term preventive, rehabilitative, semi-custodial, and medical social services in contrast to the great current emphasis on treatment of acute illness. Most chronic diseases are months or years in developing and require early diagnosis if they are to be handled effectively.<sup>28</sup> The period of treatment is, by definition, extensive. If "cure" is achieved there is often required a long "post-cure" rehabilitation. People rarely die now of the once deadly disease of diabetes, but they do require continuous medical supervision. Thus the expanding influence of chronic illness has been an important factor in enlarging the concept of "adequate medical care" to include a broad spectrum of services running from earliest positive promotion of health to ultimate rehabilitation.

These new tendencies are by no means confined to long-term disability.

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culosis or other long-term institutions. BREWSTER & McCAMMAN, *HEALTH COSTS OF THE AGED* 22-25 (Soc. Sec. Admin., Div. Res. & Stat., Rep. No. 20, 1956). Estimates based on special one-day census of hospital population made by AMA.

<sup>26</sup> 1956 and 1957 saw a small reduction in the total number of hospitalized mental patients. The President of the Natl. Ass'n for Mental Health cautioned against over-optimism with respect to this reversal in the 25-year trend. *N.Y. Times*, Nov. 22, 1957, p. 27. While discharges were up 9% in 1957, admissions were also up 4% and readmissions 9%, according to officials of the Am. Psychiatric Ass'n and the Natl. Ass'n for Mental Health. *N.Y. Times*, Apr. 21, 1958, p. 25.

<sup>27</sup> Mental and chronic illness, alcoholism, physical handicaps and aging constitute the major unmet health needs in San Francisco, according to a 1957 survey of 838 local physicians. UNITED COMMUNITY FUND OF S.F., HEALTH COUNCIL, *S.F. DOCTORS REPORT ON COMMUNITY NEEDS AND RESOURCES IN HEALTH AND REHABILITATION*.

<sup>28</sup> According to the American Cancer Society, "One half of all cases of cancer could be saved with present knowledge if individuals would seek medical attention early enough, and if the latest and best means of diagnosis and treatment can be made more generally available." Metropolitan Life Ins. Co., Adv., *Time*, March 31, 1958, p. 3.

The progress in science and technology has had significant effects on the need for other types of medical care as well. Consider the case of pneumonia. Thirty years ago, old people frequently died of it in three days. "Now," as the director of the Massachusetts General Hospital says, "they may be cured, but after 30 days of illness, with doctors and nurses in attendance. The death rate is lower, and the patients live, but they have had ten times as many days of disability and medical attendance."<sup>29</sup> The effect of such medical advances on the average medical costs of the aged is well documented<sup>30</sup> and a source of major difficulty with respect to current health insurance.

The maternal death rate has been cut about 85 per cent since 1900, but now expectant mothers see doctors regularly during their pregnancy and commonly use hospital facilities for delivery, which was not the case 50 years ago.<sup>31</sup> The dramatic decline in infant and child mortality has gone hand in hand with development of, and a growing demand for, the new specialization of pediatrics. Obstetrics and pediatrics have become two of the most important aspects of modern medicine. Both are committed to continuous health maintenance rather than episodic treatment.

The continued high incidence of automobile and other accidents, now the fourth most common cause of death,<sup>32</sup> and the exploration of new fields of surgery, especially of the brain and heart, call for the same "life or death" virtuosity which has distinguished the great surgical pioneers of the past. But success in these endeavors adds evidence to the point. Those who are saved from death by the miracles of modern surgery will frequently require long periods of indispensable care and supervision.

With such progress<sup>33</sup> and change, the once-supposed clear-cut dichotomy between health and illness becomes increasingly blurred and the

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<sup>29</sup> Clark, *Economics and Medicine*, in *MEDICINE TODAY* 144, 145 (Lectures at N.Y. Academy of Med. 1947).

<sup>30</sup> The average annual cost of personal health services for those 65 and over in 1953 was \$102 as compared with \$65 for all Americans. Although this group comprised only 9% of the population, it accounted for 13% of all medical charges. ANDERSON & FELDMAN, *FAMILY MEDICAL COSTS & VOLUNTARY HEALTH INSURANCE* 30-35 (1956). See also, BREWSTER & MCCAMMAN, *HEALTH COSTS OF THE AGED* (Soc. Sec. Admin., Div. Res. & Stat., Rep. No. 20, 1956); also, *FINANCING HEALTH COSTS FOR THE AGED* (1956 N.Y. State Conf., Albany) (1957).

<sup>31</sup> During the very brief span of time, 1935-1951, the percentage of registered births attended by a physician in hospitals rose from 37% to 90%. BUREAU OF CENSUS, U.S. DEPT. OF COMMERCE, *STATISTICAL ABSTRACT OF THE U.S.* 66 (1954).

<sup>32</sup> Nearly 10 million Americans are injured in accidents each year and about 100,000 are killed. Motor vehicle accidents alone took over 40,000 lives in 1956. Health Information Foundation, *Progress in Health Services*, Oct. 1957.

<sup>33</sup> The fact that a healthier population needs and demands more rather than less health care is no more anomalous than other aspects of economic life. It is generally true that the more we have, the greater is our demand, both "effective" and "psychological." The more we produce, the greater the demand for even larger increases in production.

concept of medical need becomes very difficult to pinpoint in space or time. There is rather a continuous spectrum with varying degrees of emphasis. It begins before we are actually ill; it does not cease when we are discharged from the hospital. Continuity and comprehensiveness are becoming essential aspects of effective medical care.

#### *D. Changing Health Mores*

The greatly enlarged potential demand for medical care implicit in the new patterns of medical need has already been partially translated into utilization and expenditure figures, both of which have been going up steadily since the early Thirties. The U.S. Bureau of Labor Statistics, after eliminating the factor of price rise, found that expenditures per family for medical care in 1950 were nearly  $2\frac{1}{2}$  times as much as in 1934-36, although family size is now smaller.<sup>34</sup> Moreover, the figures do not include the additional value of employer contributions to health insurance nor the expansion in public medical care programs.

Between 1948 and 1956, private expenditures for medical care rose from \$7.3 billion to \$12.1 billion.<sup>35</sup> Adjusted for price changes, the real increase was 27 per cent. Note the extent to which this increase has been associated with the expansion of health insurance. During this nine-year period, direct payments by consumers fell from 88 per cent of the total to 70 per cent, while insurance benefits rose from 8 per cent to 25 per cent. While health insurance—benefits plus overhead—represented only 12 per cent of all private expenditures in 1948, it accounted for 57 per cent of the \$4.8 billion increase between 1948 and 1957.

The evidence supports the view that health insurance has probably stimulated greater utilization of all medical services—the uninsured as well as the insured.<sup>36</sup> But it does not support the fear that potential demand is indefinitely expansible, subject to no predictable limits, and thus that general care is not insurable.

In the first place, the stimulus has not been as great as may appear. The overall increase of 27 per cent, in constant dollars, took place in a period of prosperity when almost all consumer expenditures were increasing as well. The proportion of per capita disposable personal income going for medical expenditures increased only 8.5 per cent between 1948 and 1956.<sup>37</sup> Even in

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<sup>34</sup> Langford, *Medical Care in the Consumer Price Index, 1936-56*. 80 MONTHLY LABOR REV. 1053, 1054 (1957).

<sup>35</sup> See Table I *supra*.

<sup>36</sup> The Health Information Foundation found that insured people utilize more medical services, of all kinds, including dental care and other typically uninsured services, and spend more for all types of medical care than do the uninsured in corresponding income groups. ANDERSON & FELDMAN, *FAMILY MEDICAL COSTS & VOLUNTARY HEALTH INSURANCE* 26-27 (1956).

<sup>37</sup> *Voluntary Health Insurance and Medical Care Costs, 1948-56*, Soc. Sec. Bull., Dec. 1957, p. 7. This calculation ignores price changes in the interim.

1957, only about five per cent of family expenditures, an average of \$280, was devoted to medical care, hardly a sum or a proportion to suggest that Americans are being profligate with health services.

But there is more direct evidence on this core question. Studies, both here and abroad, indicate that in the early years of any new health care program which reduces previous economic barriers, demand is rapidly increased, reflecting a backlog of unsatisfied need. But after this transitional and often difficult period of adjustment, a stable and adequate means of financing usually results in a stabilized demand.<sup>38</sup> This is emphasized in a recent study of the Windsor, Ontario, Medical Services plan, which provides comprehensive physicians' services on a prepaid basis—hospital services are provided by Blue Cross—to 191,000 subscribers, 85 per cent of the population.<sup>39</sup> After about 20 years of operation, the demand for physicians' services seems to have become stabilized at a point about  $\frac{1}{3}$  above the average for the uninsured. In 1954, 68 per cent of Windsor Medical Service subscribers visited a doctor compared to 58 per cent of members of non-comprehensive plans and 51 per cent of the uninsured.

Strikingly similar findings are reported for enrollees of the Health Insurance Plan of Greater New York (HIP), the largest comprehensive prepayment plan in the United States, which has been in existence about 10 years. HIP officials report that about 75 per cent of its enrollees see a doctor at least once a year compared with 57 per cent for the general New York City population.<sup>40</sup> With respect to number of visits to doctors, the Kaiser Foundation Health Plan in the San Francisco Bay Area reports an average of 4.5 visits to doctors' offices per patient per year, also after a decade of operation,<sup>41</sup> while the California Health Survey found an average of 5, including home calls, for the general population.<sup>42</sup> These comparisons suggest that removal or substantial minimization of the economic barrier results in a significant, but neither inordinate nor totally unpredictable, rise in the demand for health services. As the Windsor study concluded, "The distribution of services in the population appeared to be stable over time; many people received only a few services and a few received many. As a result,

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<sup>38</sup> For a detailed survey of the British experience see, Minister of Health, *REPORT OF THE COMMITTEE OF ENQUIRY INTO THE COST OF THE NATIONAL HEALTH SERVICE* (London, 1956). For a summary, Somers and Somers, *The Health Service: Diagnosis and Prognosis*, 27 *THE POLITICAL QUARTERLY* 410 (London 1956).

<sup>39</sup> DARSKY, SINAI & AXELROD, *COMPREHENSIVE PHYSICIANS SERVICES UNDER VOLUNTARY HEALTH INSURANCE* (1958). For summary, see Health Information Foundation, *Progress in Health Services*, Nov. 1957.

<sup>40</sup> HIP—*STATISTICAL REPORT 6* for 1955. See also *COMMONWEALTH FUND, HEALTH AND MEDICAL CARE IN NEW YORK CITY* 54 (1957).

<sup>41</sup> *Plan for Health*, Kaiser Foundation Health Plan, June 1957, p. 3.

<sup>42</sup> CALIF. DEPT. OF PUBLIC HEALTH, *HEALTH IN CALIFORNIA* 47 (prelim. mimeo. 1957).

the use of comprehensive services can be predicted statistically, so that insurance principles are applicable."<sup>43</sup>

### *The Trend to Hospital*

Changes in health mores are also revealed by relative changes in the utilization of the different types of services. As indicated in Table I, the most dramatic change has been the increase in the proportion of private medical expenditures going for hospital services: a rise from 25 per cent in 1948 to 34 per cent in 1956. The corollary has been a relative decline in the role of the other major components of medical care: the proportion going to physicians dropped from 32 to 30 per cent;<sup>44</sup> for medicines and appliances, from 25 to 21 per cent; for dentists from 11 to 9 per cent.

If the category, "physicians' services," were broken down and payments for surgical and obstetrical fees, almost always associated with hospitalized care, were added to the hospital category, the proportion of all costs going for hospital-associated illness would rise to over 40 per cent of the total. These figures are partially discounted by the far greater price rise in hospital costs than for medical costs generally, but even after adjustment is made for this factor we find that hospital expenditures increased by 30 per cent in constant dollars while all other medical expenditures increased 20 per cent between 1948 and 1956.

A major transformation has taken place in the role of the hospital in the medical care pattern of the American people. Almost three times as many Americans are admitted to hospitals today as 20 years ago.<sup>45</sup> Six out of every 100 were hospitalized during the year 1935 but by 1955 the proportion was 13 out of every 100. Hospital insurance is by far the most prevalent form of health insurance with in-hospital surgical insurance second.

There appears to be a disparity between the character of medical need revealed by the morbidity and disability studies and the actual patterns of expenditure and health insurance coverage. Whereas the emphasis in the former is on long-term chronic illness and continuous preventive and maintenance care, the emphasis in the latter is on short-term illness and acute emergencies. As a result of this dichotomy, major policy debates have taken place for years as to whether there is a conflict between the type of insurance consumers need and the kind available. Public health experts and others who emphasize demographic and morbidity data have stressed the

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<sup>43</sup> Health Information Foundation, *Progress in Health Services*, Nov. 1957, p. 3.

<sup>44</sup> Twenty-five years ago the proportion of the consumer's medical dollar going to doctors was about twice as great as for hospitals. For a somewhat different breakdown of the consumer's medical dollar and a discussion of definitions and methods of allocating the different components, see ANDERSON & FELDMAN, *FAMILY MEDICAL COSTS & VOLUNTARY HEALTH INSURANCE* 22-23, 109-11 (1956).

<sup>45</sup> In 1956, there were over 22 million admissions. *Hospitals*, Part 2, Aug. 1, 1957, p. 341.

need for comprehensive care. The American Medical Association and others who formerly opposed comprehensive insurance could point persuasively to actual patterns of utilization.

The reasons for the "trend to hospital" are too many and too complex for adequate treatment here. However, some understanding of the major causes is essential to any effort to predict the future course of this trend and hence the appropriateness of the present dominant pattern of health insurance. There appear to be three broad sets of factors:

1. There has been a widespread appreciation of the new central role of the modern hospital both as symbol and physical embodiment of the scientific revolution in medicine. The hospital stands for the oxygen tent, the blood bank, the operating room, and the other miraculous instruments through which modern medicine has demonstrated its ability to save or to deny life.<sup>46</sup> The American people have insisted on taking advantage of this life-saving institution in greater and greater numbers.

At the same time, hospital care, rightly or wrongly, is generally associated with high, even catastrophic, costs. It is not surprising that, in spite of the admonitions of the public health experts, the average American appears to have felt that his first insurance requirement was against these costs. The attitude of insurance carriers, doctors, and other interested parties reinforced this conviction.

2. There is a mutually interactive relation between demand and supply. Once hospital insurance became the dominant health insurance pattern, it is understandable that in the almost total absence of other types of health insurance people would try to stretch the available protection to cover parts of their uninsured costs. A disproportionate supply of one type of medical service can lead, at least temporarily, to a distorted demand for that service. In any case, health insurance has now replaced income-level as the major socio-economic influence on the hospitalization of Americans. Recent studies are consistent in pointing to the decisive influence of health insurance in raising utilization rates: the insured enter hospitals more often and use more days on the average than the uninsured. The Health Information Foundation (H.I.F.) 1953 survey found that hospital admission rates were

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<sup>46</sup> A counter-trend may be identified in the effective use of sulfas and antibiotics to minimize the incidence and seriousness of scarlet fever, mastoiditis, and certain other diseases which once required hospitalization. However, this reduction in the need for hospital care in certain situations is minor compared to the vast increase in other situations. For example, Beth Israel Hospital of Boston reports a 9-fold increase in admissions for arteriosclerotic heart disease and a similar increase for diabetes between 1932 and 1952. For a fascinating picture of some major changes which have taken place in a typical hospital population during these two decades, see Health Information Foundation, *The General Hospital in Transition*, Progress in Health Services, Sept. 1957.



14 per 100 for the insured, 9 per 100 for the uninsured. The insured averaged 100 hospital days per 100 persons a year; the uninsured 70.<sup>47</sup>

This has resulted in widespread charges of "abuse" of hospital insurance by patients and/or doctors.<sup>48</sup> There is wide difference of opinion among the experts as to the extent of such "abuse," if any, and its significance, but there is an increasing consensus as to the built-in tendency toward overutilization of hospital services in the dominant health insurance pattern. This conclusion is reinforced by evidence that, under comprehensive health insurance, hospital utilization rates are significantly lower than where only hospital and surgical costs are covered.

According to Dr. Frederick Mott, "Blue Cross subscribers nationally utilized an average of 995 days of hospital care per 1000 persons in 1956. In Michigan the figure was 1100 days per thousand. On the other hand, the utilization figure for Kaiser Plan subscribers in Northern California was 624 days, for Group Health in Seattle it was 562 and for Group Health in the District of Columbia it was 546."<sup>49</sup> A recent study of comparative hospitalization experience of HIP and Blue Shield subscribers in New York City, with similar Blue Cross coverage, found that approximately 8 out of 100 HIP enrollees were hospitalized in a year as compared to 10 out of 100 Blue Shield enrollees.<sup>50</sup>

The contention is that the availability of physicians' services on a pre-paid basis for out-patient diagnosis and early treatment tends to reduce the incidence of hospitalized illness. This theory is receiving increasing recognition. For example, Dr. George Wheatley, vice-president, Metropolitan Life Insurance Company, quotes with approval this statement by another doctor, "I think an insurance policy sold without office or outpatient cover-

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<sup>47</sup> ANDERSON & FELDMAN, *FAMILY MEDICAL COSTS & VOLUNTARY HEALTH INSURANCE* xiv-xv (1956). With respect to average length per stay, the experience is contrary: the insured averaged 7 days; the uninsured 8.3.

<sup>48</sup> For example, a 1952-53 survey sponsored by the Michigan State Medical Society reported that "One-third of all hospitalized patients whose care was paid for by a third party involved some type of 'faulty' use of hospital beds. For self-pay patients 'faulty' use existed in 14 per cent of all cases reviewed. About one-fifth of the payments made to hospitals by the prepayment agency . . . were attributable to 'faulty' use." "Faulty" utilization was found due mainly to "(1) overstay, (2) admissions for medical inventory, (3) hospitalization for convenience of patients or family, and (4) excess use of drugs and laboratory and X-ray facilities." *PREPAYMENT AND THE COMMUNITY* 290-91 (Becker ed.) (Commission on Financing of Hospital Care 1955).

<sup>49</sup> Address to Economic Club of Detroit, Feb. 1958, mimeo., p. 7. Dr. Mott is executive director, Community Health Ass'n of Detroit.

<sup>50</sup> Densen, Balamuth & Shapiro, *Prepaid Hospital Care and Hospital Utilization* 34 (Amer. Hospital Ass'n Mono. No. 3, 1958). There was little difference in length of stay between the two groups—7.6 days for HIP patients, 7.2 for Blue Shield. But total annual utilization varied from 588 days per 1000 population for HIP enrollees to 688 for Blue Shield. Special care was taken to try to eliminate possible income and other socio-economic differences between the two groups.

age is a greater cause of abuse and increased cost than any other single factor."<sup>51</sup>

3. In addition to health insurance, many other socio-economic factors are known to influence hospital utilization. The effect of age in increasing utilization rates has already been noted. Contrary to popular belief, despite higher female admission rates during child-bearing years, male utilization of hospitals is higher than female due primarily to longer stays.<sup>52</sup>

Among the insured, the lower the income the higher the admission rates and the greater the number of hospital days used.<sup>53</sup> The effect of increased education is closely related. A 1951 New York study indicated that persons with less than 9 years schooling averaged significantly longer hospital stays than those with more education, regardless of age or insurance status.<sup>54</sup> With respect to hospital admissions, however, the situation is at least partially reversed.<sup>55</sup> An important British study found that marriage appears to be a safeguard against hospitalization.<sup>56</sup> The same phenomenon appears to prevail in this country. This and the high male utilization rate suggest the important role of home nursing facilities. Home environment and even sheer loneliness may be swelling hospital lists, especially of the aged. During the past few decades, the hospitals have been increasingly called on to provide services which other facilities might have provided more economically.

From these three factors it would appear that the increasing utilization of the hospital is, in large part, well warranted by its increased technological importance in modern medical care and by the backlog of need on the part of many people to whom it was previously denied. In part, however, demand has been artificially skewed by the general limitation of insurance to this particular type of service, by the lack of other community facilities and services, and by inadequate consumer appreciation of the importance of preventive care.

But this situation appears in a stage of transition. Health insurance

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<sup>51</sup> Wheatley, *Voluntary Health Insurance—Progress and Problems*, 257 *NEW ENG. JOUR. MED.* 118 (1957). Linked in this condemnation are surgical policies that "pay by the stitch."

<sup>52</sup> H. I. F., *Progress in Health Services*, May 1958, pp. 3–4.

<sup>53</sup> ANDERSON & FELDMAN, *FAMILY MEDICAL COSTS AND VOLUNTARY HEALTH INSURANCE* 58, 65 (1956).

<sup>54</sup> COMMONWEALTH FUND, *HEALTH & MEDICAL CARE IN NEW YORK CITY* 162 (1957).

<sup>55</sup> *Id.* at 153. If obstetric conditions are excluded, the correlation is more comparable to length of stays. This discussion relates to hospital utilization only. With respect to utilization of medical care generally, there appears to be a positive correlation between years of schooling and amount of utilization (*id.* at 83).

<sup>56</sup> ABEL-SMITH & TITMUS, *THE COST OF THE NATIONAL HEALTH SERVICE IN ENGLAND AND WALES* 145 (1956). It was reported that, in relation to their number in the total adult population of the country, the single, widowed and divorced make about double the demand on hospital facilities.

itself has helped to stimulate health education as well as health consciousness. The people are becoming more critical. As early as 1953, the Health Information Foundation-National Opinion Research Center study of Blue Cross-Blue Shield and Aetna subscribers found that  $\frac{1}{4}$ - $\frac{1}{2}$  were dissatisfied with their present insurance coverage, primarily on the basis of too narrow protection.<sup>57</sup> Organized labor is pressing, with increasing success, for "supplementary benefits"<sup>58</sup>—out-patient diagnostic services, home and office doctor visits, dental care, drugs, eye care, etc. These are already beginning to spread. The continued growth of HIP, the Kaiser Plans, and a number of other comprehensive prepayment organizations, in spite of the frequent opposition of state medical societies, is testimony to the persistent strength of the demand for comprehensive coverage. So is the rapid growth of the new "major medical" and "comprehensive" policies sold by the commercial carriers<sup>59</sup> and the somewhat belated but now strenuous efforts on the part of a few Blue Cross and Blue Shield organizations to extend out-patient and non-hospitalized medical coverage.

Leading authorities in medical economics agree on this point. For example, Dr. Odin Anderson has said, "The drive toward greater comprehensiveness of benefits has been so relentless that the principle itself is not an issue any more and current discussion and worry are now directed to 'how comprehensive' and how can it be administered."<sup>60</sup> Dr. Mott has said, "In this evolutionary situation [with respect to health insurance] the most powerful force shaping events is the increasing demand of the public for more comprehensive services and more complete financial protection."<sup>61</sup>

The new demand is in part a tribute to the success of hospital and surgi-

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<sup>57</sup> Health Information Foundation, *Progress in Health Services*, June 1957, p. 1.

<sup>58</sup> Helen Nelson, assistant chief, Div. of Labor Stat. and Res., Cal. Dept. of Industrial Relations, has supplied what is probably the most specific possible definition of "supplementary benefits": "I am going to assume that this phrase, like health and welfare, has a connotation—not a definition—and that it means those benefits we don't now have but would like to have." *Supplemental Benefits in Health Care*, p. 3 (address to AFL Institute, Santa Barbara, July 1957).

<sup>59</sup> These will be discussed in detail in Part Two of this article to appear in the next issue of *The California Law Review*.

<sup>60</sup> Health Information Foundation, *Issues in Voluntary Health Insurance* 6 (mimeo., 1957). The full impact of this statement is clearer if one compares it with a statement by the AMA economist, Dr. F. G. Dickinson, on the same subject at the time of the President's Commission report only five years ago: "The commission's insistence on comprehensive insurance . . . not only suggests that the commission's ideal citizen is a 'kept man' in our society but places the commission on record as being perfectly willing to postpone the day when our voluntary plans will be able to rid themselves of the curse of these 'five-and-dime' claims and then proceed to expand their coverage of catastrophic illness higher and ever higher." *BUILDING HEALTH BY COMMISSION* 8 (AMA Bull. 93, 1953). Apparently Dr. Dickinson failed to anticipate the development of a type of voluntary health insurance which has combined the drive for "comprehensive care" with the "deductible" principle.

<sup>61</sup> Address to Economic Club of Detroit, Feb. 1958, mimeo., p. 2.

cal insurance in their limited fields in pointing the way towards further advances. In part it is a simple recognition of the fact that the largest and most stubborn part of medical costs still involves non-hospital, *i.e.*, non-insured costs. The growing demand for "comprehensive" health insurance—which, of course, does not mean coverage of all costs, but does mean a much greater coverage than is now available—appears to signify a reconciliation of basic need with expressed demand. The capacity of voluntary health insurance to cope successfully with this demand will be a major determinant of its future.

## II

### THE ORGANIZATION OF MEDICAL SERVICES

The traditional symbol of medical care in this country—the family doctor with his little black bag, part healer, part priest, part family counselor, practicing alone with perhaps the assistance of one nurse-receptionist, coping more or less adequately with most of the medical and surgical problems of his patients and sending them to a specialist or to a hospital only in the event of extreme complication—still persists, especially in small towns and rural areas. But, his ranks have been rapidly dwindling. The developments discussed in the preceding section could not avoid fundamentally influencing the organization as well as the character of medical care. The spread of health insurance and the widespread interposition of a third party into the traditional doctor-patient relationship have also had a great impact.

#### *A. The "Institutionalization" of Medicine*

The \$17 billion health services industry<sup>62</sup> is now one of the nation's largest. A vast army of two million medical workers were engaged in these services in 1955. (See Table II.) In terms of personnel employed, the 1950 census listed health services as ranking seventh among the seventy-seven categories in the industry classification list, and it was clearly one of the fastest growing. During the decade 1940–50, employment in the health services increased by 600,000, or about 59 per cent, as compared with 25 per cent for all industries.<sup>63</sup>

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<sup>62</sup> See note 10 *supra*.

<sup>63</sup> PUBLIC HEALTH SERVICE, U.S. DEPT. OF HEALTH, EDUCATION & WELFARE, HEALTH MANPOWER CHART BOOK 3 (1957). Of the top ranking industries, only two—construction and wholesale trade—showed larger proportionate increases.

TABLE II  
MAJOR OCCUPATIONS IN THE HEALTH SERVICES<sup>a</sup>

Professional, technical, and kindred workers.....	1,261,000
Chemists .....	3,000
Chiropractors .....	25,000
Dentists .....	98,000 <sup>b</sup>
Dietitians and nutritionists .....	22,000
Engineers, sanitary and others.....	5,000
Health program specialists.....	3,000
Librarians, medical .....	7,000
Natural scientists (biophysicists and others).....	4,000
Nurses, professional .....	430,000
Nurses, student professional .....	113,000
Optometrists .....	17,000
Osteopathic physicians .....	12,000
Pharmacists .....	111,000
Physicians and surgeons.....	225,000 <sup>b</sup>
Psychologists .....	4,000
Rehabilitation counselors .....	2,000
Social workers .....	11,000
Statisticians and actuaries .....	2,000
Technicians	
Medical laboratory .....	50,000
Dental and dental hygienists.....	26,000
X-ray .....	50,000
Therapists .....	24,000
Veterinarians .....	17,000
All other workers.....	690,000
Assistants, physician's office.....	75,000
Assistants, dentist's office.....	55,000
Attendants, hospital and institution.....	337,000
Managers and officials	
Health department sanitarians.....	8,000
Hospital and medical program directors.....	9,000
Medical record personnel.....	15,000
Midwives .....	15,000
Opticians .....	1,000
Practical nurses .....	175,000
TOTAL .....	1,951,000

<sup>a</sup> Does not include several hundred thousand additional pharmacists, veterinarians, manufacturing employees and others working in the manufacture of drugs, appliances, and related health fields not classified by the census as "health services."

<sup>b</sup> Includes 1955 graduates and an unknown number of retired practitioners. The National Health Council reports 192,000 practicing physicians in 1957. N.Y. Times, Sept. 3, 1957, p. 29.

Source: U.S. Dept of Health, Education and Welfare, Public Health Service, *HEALTH MANPOWER CHART BOOK 1-2* (Publ. No. 511, 1957).

In addition to the great overall growth, perhaps the most striking single fact is the extent to which physicians' services are increasingly being augmented by those of other health personnel. Between 1900-1950, the number of doctors in the United States rose 58 per cent as compared with almost

4,000 per cent for professional nurses, 156 per cent for dentists and 410 per cent for pharmacists and others. In 1900, 2 out of 5 professional health workers were not physicians; in 1950, 4 out of 5. The percentage increase in doctors has not kept pace during this period with the increase in total population (99 per cent) or the increase of the total labor force (103 per cent).<sup>64</sup>

The increasing totals and the proportionate shift in personnel are, in part, explained by the rapidly enlarged and changing character of demand already noted and, partly, by the development of organizational arrangements which have made possible the more efficient use of doctors' time and skills. In virtually every important sector of the large and varied industry the doctor now works in teams or combinations, both with other doctors and with other medical and paramedical personnel. Sometimes through highly formal and organized groupings, sometimes quite informally and loosely, modern medicine operates mainly in or through what, for lack of a better word, may be called "institutional" arrangements.

Consider, for example, what has happened to medical research and education. These two basic elements for continued medical progress are now almost completely institutionalized. Today's research-minded doctor with his expensive laboratory and highly-specialized equipment<sup>65</sup> is as unlike Sinclair Lewis' Arrowsmith, who kept his microscope and slides in the back of his small office, as the post-graduate medical student serving a residency in one of our great teaching hospitals is unlike his predecessor of fifty years ago, often apprenticed to a single family doctor.

### *The Structure of Medical Practice*

Specialization is an aspect of increasing total knowledge and the resulting variety of skills in a profession. There is a hen-and-egg relationship between the growth of specialization and the elaboration of medical education. There are now 32 specialized medical careers whose standards and requirements are set by 19 examining boards accredited by the Council on Medical Education. In most cases preparation for the examinations is done through post-graduate hospital residencies of two to six years in addition to the year of internship.

The ratio of full-time specialists to all physicians has moved steadily

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<sup>64</sup> *Id.* at 5.

<sup>65</sup> In 1957, about seven times as much was being spent on research as in 1947. The total is now approaching \$400 million a year. About  $\frac{2}{3}$  comes from the federal government; the remainder from industry, chiefly drug manufacturers, philanthropy, and institutional endowment. Much of the work is carried on in large-scale projects involving very expensive equipment and specialized teams of workers. About half is done in medical schools, 30% by industry, and 20% in government laboratories. C. V. Kidd, Chief, Office of Research Planning, Nat'l Institute of Health, Letter to Authors, Apr. 25, 1958.

and quickly upward from 11 per cent in 1923 to 39 per cent in 1955.<sup>66</sup> Among physicians in private practice the speed of the shift may be seen from the following data covering only a six-year interval:

	1949	1955
Full-time specialist .....	37%	44%
Partial specialist .....	15%	14%
General practitioners.....	48%	42%

More impressive in some ways is the fact that general practice has not only declined relatively but also in absolute numbers: In 1955, the United States had only 85,000 G.P.s in private practice, 22 per cent fewer than in 1940. (About  $\frac{1}{4}$  of these reported "some specialization.") During the same period, the number of full-time specialists in private practice nearly doubled.<sup>67</sup>

There are, however, significant counterforces. Professional concern about the consequences of inadequate general practice resulted in the founding of the American Academy of General Practice, which has made determined efforts to upgrade the G.P. through special training courses at both under-graduate and post-graduate levels, by exclusive concentration on medicine and rejection of claims to surgical competence, and by arrangements for better hospital connections. Such steps have had positive results. Some of the new G.P.s are difficult to distinguish from specialists in internal medicine except that they may also handle obstetrics or pediatrics.

Equally important is the increasing recognition, particularly in large group practice organizations, of the indispensability of a "generalist" to coordinate the knowledge and skills of the specialists as applied to an individual or even to a family-group. It may be that we will see some reversal of the recent overproduction of specialists in favor of more "personal physicians." It is not yet clear just who this future "personal physician" will be: a new-style G.P., an internist with a broad knowledge of general practice and perhaps even psychiatry, or some other hybrid who emerges to meet the obvious need. But, in any case, it is clear that he will have to fit into the new institutional framework of medical practice, for that new framework is already here.

### *"Combined Practice"*

The increase in specialization inevitably led to the evolution of new forms of medical care organization, especially the growth of various types

<sup>66</sup> PUBLIC HEALTH SERVICE, U.S. DEPT. OF HEALTH, EDUCATION & WELFARE, HEALTH MAN-POWER CHART BOOK 31 (1957) (based on AMERICAN MEDICAL DIRECTORY, tables 3-4 (1956)).

<sup>67</sup> *Id.* at 30. Of some 20,000 hospital residencies only 500 were for general practitioners in 1956; 198 of these were reported going begging. *Time*, April 2, 1956, p.36. Some of the best teaching hospitals keep general practitioners out completely or restrict them to minor medical care.

of "combination practice" and expanded hospital services. The myriad advances in science and technology which have led to specialization have also created increasing interdependence of medical practice, made general practitioners dependent upon specialists, specialists upon each other, and all upon ancillary personnel, large-scale facilities, modern laboratories, hospitals and clinics. A lone physician can no longer render complete medical care.<sup>68</sup> It is not only beyond individual capacity for knowledge and skill, it is also financially unfeasible—so great is the capital investment now required to equip and operate an office adequate to the demands of modern medicine.

Cooperative arrangements among doctors, formal or informal, are now virtually universal in the United States. Even the most individualistic practitioner will have a list of specialists to whom he may refer patients for diagnosis or treatment, and will try to establish working relations with a hospital. The already widespread tendency of American doctors to abandon neighborhood practices and set up offices in hospitals<sup>69</sup> or other centrally-located medical buildings, where at least some of the heavy overhead necessary to maintain individual practice may be reduced, is another example of informal cooperation within the profession.

For a wide variety of practical reasons, however, including the obvious economy, the physicians' convenience, and more effective service, there has developed a broad spectrum of various types of formally organized "group practice" or "combined practice." These include partnerships of many kinds, involving few or many doctors, general practitioners and specialists in various combinations; a great variety of private clinics; hospital groups; industrial groups sponsored by labor, management, or both; and consumer-sponsored groups. The many types of arrangements within this spectrum do not lend themselves to easy classification and considerable semantic confusion has resulted. The lack of agreement as to the precise definition of group practice, the widespread tendency for doctors, particularly specialists, to engage in more than one form of practice, and the heated partisan controversy which has long surrounded the term has made it exceedingly difficult to evaluate the significant changes in the organization of medical practice which have, in fact, been taking place at a rapid rate.<sup>70</sup>

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<sup>68</sup> The eminent Dr. Will Mayo pointed out long ago, "It has become necessary to develop medicine as a cooperative science; the clinician, the specialist and the laboratory workers uniting for the good of the patient . . . . The people will demand, the medical profession must supply, adequate means for the proper care of patients, which means that individualism in medicine can no longer exist." CLAPESATTLE, *THE DOCTORS MAYO* 530 (1941).

<sup>69</sup> For a report on this trend and opinions pro and con, see C. R. Rorem and D. L. Laughlin, *Private Office Practice at Hospitals*, *The Modern Hospital*, March 1957, p. 55.

<sup>70</sup> Much of the voluminous literature on "group practice" is more propagandistic, pro or con, than enlightening. The first major study was made in 1931 by C. R. Rorem for the Com-



As a working definition of "group practice," that of the Public Health Service has been most widely accepted: "a formal association of three or more physicians providing services in more than one medical field or specialty, with income from medical practice pooled and redistributed to the members according to some prearranged plan."<sup>71</sup> The AMA definition used in its 1956-57 survey—"groups of four or more physicians working together in collaborative practice in which the income was pooled and the earnings divided among the physicians on some prearranged agreement"<sup>72</sup>—differs essentially only in that it does not require the group to be multi-disciplined.

Dr. C. Rufus Rorem, executive director, Hospital Council of Philadelphia, may have put his finger on the heart of the matter as well as indicated the futility of precise definitions when he said, "Group practice is a process, rather than a form of organization. The central theme—a common interest in the patient—is always present. But the variations are numerous."<sup>73</sup> They include some of the most famous clinics in the country, Mayo, Lahey, Russell Lee of Palo Alto, Ross-Loos of Los Angeles and Crile of Cleveland.

For our present purpose—the identification of long-range underlying trends—it is sufficient to point out that at least three different forms or stages of "combined practice" have emerged, each significant in its own right. The term "combined practice" itself is a catch-all to indicate all forms of non-individual private practice, *e.g.*, where two or more doctors

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mittee on the Costs of Medical Care. Another landmark study was HUNT & GOLDSTEIN, *MEDICAL GROUP PRACTICE IN THE U.S.* (Public Health Service Pub. 77, 1951). A recent survey by the AMA's Council on Medical Service and the Am. Assoc. of Med. Clinics is reported in 161 J.A.M.A. 1391 (1956) and 164 J.A.M.A. 1338 (1957). For a brief introduction, see Clark & Hapney, 273 *Group Practice*, *THE ANNALS OF THE AMER. ACAD. OF POLIT. & SOC. SCIENCE* 43 (1951). For special emphasis on California, see Weimerman, *Medical Group Practice in California*, 76 *CALIFORNIA MEDICINE* 383 (1952).

<sup>71</sup> HUNT & GOLDSTEIN, *MEDICAL GROUP PRACTICE IN THE U.S.* 1 (Public Health Service Publ. 77, 1951).

<sup>72</sup> 164 J.A.M.A. 1338 (1957).

<sup>73</sup> Rorem, *Pattern and Problems of Group Medical Practice*, 40 *AM. JOUR. PUBLIC HEALTH* 1521 (1950). "They vary in size, from two physicians who may call themselves a group under certain conditions, to several hundred physicians in some of the larger groups. They also vary in the purposes for which they are formed: some provide comprehensive medical care involving most or all of the major medical specialties; others consist of physicians all engaged in the same field, such as radiology, internal medicine, or industrial surgery; some are purely diagnostic groups; some consist exclusively of physicians devoting their full time to the group; and others are composed of part-time practitioners . . . [T]he manner in which they conduct their business affairs is also quite varied. The proprietorship sometimes is limited to one man and all the other physicians are employees of that individual. Other groups are owned by a small group . . . who hire the other physicians in the group and maintain them in the status of employees. Many . . . are partnerships in which all the members . . . share equally in the management and participate in the decisions." 2 *BUILDING AMERICA'S HEALTH* 241-42.

share office space, nursing or clerical assistance, or other physical facilities. The three forms may be characterized primarily by (1) sharing of facilities, (2) sharing income, and (3) sharing responsibility for individual patients.

Each of these three developments represents an important step in an overall process whose advantages are qualitative as well as quantitative. As Dr. Gregg has pointed out, all professional cooperation, even the hasty conference in a hospital corridor or adjoining offices, is conducive to better medical care.<sup>74</sup> The different types of groups are growing at very different rates—and not unnaturally the most advanced type at the slowest pace—but they appear to be, at least in the long run, complementary rather than contradictory trends.

Striking regional variations still persist with the greatest growth of private clinics in the west and midwest and in smaller cities. On the other hand, the greater development of full-time hospital staffs and of high quality out-patient services in many outstanding eastern hospitals reflect the same basic trend in a different form. Indeed, some experts believe that "The general hospital is the natural site for the greatest development of group practice in America."<sup>75</sup>

About one-sixth of all group practice organizations are associated with prepayment of fees or health insurance.<sup>76</sup> This category, which includes Ross-Loos, the Kaiser Plans of California and Washington, HIP, and the group health cooperatives of Seattle, Washington, and the District of Columbia, is distinctive and controversial, not because of group practice or even of prepayment but because the conjunction of the two imposes a not universally popular service-responsibility on the participating doctors and results in what the non-participating doctors call a "closed panel."

Regardless of the varying types, there can be no question about the direction and vitality of the overall trend. In 1946, Doctors Hunt and Goldstein found 368 groups which conformed to the P.H.S. definition. By 1951, 91 more had come to their attention. The President's Commission in 1952 estimated the number at 500-600. In 1958, the executive director of the

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<sup>74</sup> "The service given a patient by group practice gains in quality by the criticism of the other members of the group, whether the criticism be tacit or fully expressed. Whether we realize it or not, the presence of merely a competent trained nurse tends to raise the doctor's level of performance." GREGG, *CHALLENGES TO CONTEMPORARY MEDICINE* 60 (1956).

<sup>75</sup> Rorem, *Pattern and Problems of Group Medical Practice*, 40 *AM. JOUR. PUBLIC HEALTH* 1521, 1522 (1950).

<sup>76</sup> A. Deutsch, *Group Medicine*, Part 2, Consumer Reports, Feb. 1957, p. 83. For a 1954 survey of 174 group-practice plans with prepaid benefits and about 3 million enrollees, see Brewster, *Group-Practice Prepayment Plans: 1954 Survey*, Soc. Sec. Bull., June 1956, p. 3. In California, prepaid group practice is relatively more significant than in other states. In 1950, nearly 500 doctors, over half of all group-practitioners in the state, were in prepayment organizations as compared to only 20% in the U.S. Weinerman, *Medical Group Practice in California*, 76 *CALIFORNIA MEDICINE* 383, 385 (1952).

American Association of Medical Clinics estimated the total number of groups at 850 with approximately 12,000 doctors.<sup>77</sup> The AMA Council on Medical Service, in its recent survey, found that the growth of group practice since World War II has been "phenomenal."<sup>78</sup>

It is impossible, for all the reasons indicated and more, to supply any precise figures as to the proportion of physicians in the various forms of medical practice. There seems to be agreement, however, that only a little over half of all active doctors are now in solo practice. The remainder are divided between full-time salaried positions<sup>79</sup> and the various forms of combined practice, in ratios which vary according to definition.<sup>80</sup>

Variations among recent medical school graduates are especially indicative for determining trends. According to the Association of American Medical Colleges, among graduates of the class of 1935, polled in 1950 (fifteen years after graduation) 74 per cent were in individual practice, including both G.P.s and specialists; of the class of 1940, also surveyed in 1950, 66 per cent were in individual practice; of the class of 1945, surveyed in 1954, the percentage was only 47. The remainder were widely distributed among partnerships, government, teaching and research, hospitals, etc.<sup>81</sup> The relationship of these data to the acceleration of specialization is suggestive. Of the 1945 graduates, the proportion in solo practice was 70 per cent among G.P.'s and only 42 per cent among specialists. The significance of this is underlined by the fact that 74 per cent of the 1945 graduates were full-time specialists in 1954.

A more recent poll of medical students by the National Opinion Research Center indicates that only one in four wants a completely independent practice. Thirty per cent say they want group or partnership practice; another 31 per cent wish to share facilities; the remainder prefer salaried jobs. Seven out of 10 expect to specialize.<sup>82</sup>

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<sup>77</sup> E. P. Jordan, Letter to authors, Mar. 10, 1958. Dr. Jordan classifies them according to size: (1) those comprising at least 7 full-time doctors representing at least 5 major specialties—about 150 clinics with 4,000 doctors; (2) at least 5 full-time doctors in 3 specialties—around 200 groups with 3,000 doctors; and (3) smaller groups—about 500 with 5,000 doctors.

<sup>78</sup> 164 J.A.M.A. 1340 (1957).

<sup>79</sup> See text at note 91 *infra*.

<sup>80</sup> Dr. Lowell T. Coggeshall, president, Assoc. of Am. Med. Colleges, estimates that "about 54% of all active physicians are in solo practice, somewhat less than 15% are in groups or employed by other physicians, and the remainder are on the full-time staffs of medical schools, hospitals, health departments, or industrial establishments." NATIONAL HEALTH—SOCIOLOGICAL ASPECTS 65 (mimeo. 1956). A 1957 estimate by Medical Economics gives the following breakdown: solo practice, 56%; expense- or space-sharing, 11%; two-man partnerships, 9%; larger partnerships and groups, 7%; salaried assistantships, 3%; other forms of salaried practice, 14%. Oct. 1957, pp. 16–17. This study excludes two major sources of salaried practice—hospital interns and residents and military medical officers.

<sup>81</sup> Weiskotten & Altenderfer, *Trends in Medical Practice*, Jour. of Med. Educ., July 1956, Part 2, p. 70.

<sup>82</sup> Taylor, *Tomorrow's Doctor Won't Go It Alone*, Medical Economics, Sept. 1957, pp. 306–07. Interest in solo practice and general practice appears to decline as schooling advances.

### *The Hospital as Center of the Medical World*

Perhaps the most important and dramatic example of the institutionalization of medicine is the modern hospital. "Within living memory an age-old institution has been transformed from a hostel for sick-poor into a medical center for everyone."<sup>83</sup>

The growing demand for hospital services, already discussed, has been met by a tremendous expansion in United States hospital facilities, both in-patient and out-patient. Between 1910 and 1955, the United States population increased by 80 per cent but hospital beds increased 280 per cent. Out-patient<sup>84</sup> departments or hospital clinics, once used almost exclusively for charity patients, have also expanded to the point that in 1952 some 3,500, over half of the hospitals reporting on the subject, had such departments. About five-sixths of the large general hospitals (those with over 250 beds) maintain them. New York City's largest hospitals report that 70 to 80 per cent of out-patient services are now paid for in full.

There is a remarkable world-wide unanimity of professional opinion with respect to the central role of the general hospital in modern medical care. In 1948, the professional journal, *Modern Hospital*, devoted a special issue to "The Hospital of the Future" to which leading hospital administrators, physicians and architects contributed. Their major theme, as they looked 50 years ahead, can be summed up in the words of Dr. E. L. Crosby: "The greatest change will be the metamorphosis of the hospital from a diagnostic and curative headquarters into a community health center, with all that this entails. The outpatient department . . . will be at least of equal importance with inpatient facilities . . ."<sup>85</sup> All agreed that group practice would be the major pattern for outpatient as well as inpatient care.

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<sup>83</sup> DAVIS, *MEDICAL CARE FOR TOMORROW* 111 (1955). There are, of course, many kinds of hospitals with widely varying kinds of services. A major distinction is between those serving long-stay patients, especially with mental illness and tuberculosis, and the short-term general and special hospitals. In 1956, the latter accounted for 87% of the total number of institutions, 98% of new patient admissions and 78% of total costs of running the hospitals, but had only 48% of the beds and 42% of the average daily hospital population. *Hospitals*, Aug. 1, 1957, Part II, pp. 5, 314. While the present discussion concentrates on the general hospital, the problems and challenges facing the long-term institutions, in view of current trends with respect to mental and chronic illness are, in some ways, even greater and will inevitably affect ultimate decisions with respect to the financing of medical care.

<sup>84</sup> The term "outpatient services" is sometimes used to refer to all medical care for non-hospitalized illness; more often it is confined to hospital services rendered patients not admitted to hospital beds, i.e., "vertical" as opposed to "horizontal" patients.

<sup>85</sup> Aug. 1948, p. 57. For a striking example of one of these "health centers," consider the Bellevue-N.Y.U. Medical Center in New York City. This vast complex of teaching, research and medical care occupies 15 buildings running from 25th to 30th Streets. It has 2,670 patient beds and an average daily population of nearly 10,000, including personnel and patients. It has its own post office, two public schools, a prison, several libraries, three full-scale chapels, a mortuary, a pathological laboratory, and even a state supreme court (for commitment proceedings

In 1952, the President's Commission said, "Hospitals are at the heart of our modern medical system . . . . The modern hospital has developed into the basic institution providing technical facilities for the promotion of health, the diagnosis and treatment of disease, and the rehabilitation of the disabled. More and more, it is becoming responsible for a continuing flow of health services to the community, supplying preventive services in health centers at one end of the line and rehabilitative and home care services at the other end. Moreover, the hospital has become the most important and most expensive factor in medical education."<sup>86</sup>

In 1957, the World Health Organization's Expert Committee on the Organization of Medical Care, composed of medical leaders from many nations, declared that the general hospital cannot be an isolated institution, but that it should rather be part of an overall social and medical organization intended to provide complete health care, both curative and preventive.<sup>87</sup>

Virtually all hospital experts stress the importance of the general hospital as the core of a community or regional network of teaching facilities, smaller hospitals, health centers, nursing homes and other medical facilities.<sup>88</sup> The Hill-Burton Hospital Construction program, the main source of hospital financing since World War II, adopted the regional pattern as a guiding principle and a number of such plans are already in existence.<sup>89</sup>

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of psychiatric patients). It is connected with three medical colleges, those of Cornell, Columbia, and New York Universities. The members of their teaching staff unite in caring for Bellevue's patients. In return for this work, done on a voluntary basis, the doctors receive the privilege of doing research among Bellevue's daily average of 2,500 ward patients and 1,500 out-patients. Any patient whose condition requires it has access to the individual or collective talents of 1,000 doctors on the attending staff, in addition to a house staff of 450 interns and residents. As many as 15 specialists may meet to analyze and diagnose a single patient's problems. The hospital's operation costs the city \$21,000,000 a year. In April 1958, Mayor Wagner responded favorably to an architect's plan for construction of a \$75 million, 30-story new Bellevue.

<sup>86</sup> 1 BUILDING AMERICA'S HEALTH 22.

<sup>87</sup> ROLE OF HOSPITALS IN PROGRAMMES OF COMMUNITY HEALTH PROTECTION 4 (W.H.O. Technical Rpt. Ser. No. 122, 1957).

<sup>88</sup> Among these "other medical facilities" special attention is now being given to the development of "homesteads" or "half-way houses," for those who need semi-institutional care but do not require full hospital services, and to "home care" programs for those who need supervision only. The implication of these programs is great both for future control of hospital costs and for the organization of medical practice.

<sup>89</sup> The principle was first applied in the U.S. in 1931 by the Bingham Associates Fund of Boston and was designed primarily to overcome the isolation of rural practitioners in Maine and western Massachusetts by close working relations between doctors and community hospitals in those areas and the New England Medical Center. Thirty-two hospitals are now involved. A comprehensive regional plan, covering 30 hospitals, has been in operation since 1946 by the Regional Hospital Council of Rochester, N.Y. A variation of the regional principle is the chain of 10 hospitals operated by the United Mine Workers in the bituminous coal-mining region of Virginia, West Virginia, and Kentucky. For other plans and problems, see 2 BUILDING AMERICA'S HEALTH 246-52.

There can be little doubt that the modern hospital is becoming the physical and intellectual center for all aspects of medicine: practice, professional education, research, post-graduate stimulation and community health education.

### *B. Changing Methods of Physician Remuneration*

One of the important by-products of the trends to hospital and combined practice has been the development of new methods of remunerating doctors. The traditional fee-for-service method is still dominant, but other methods are spreading rapidly. A 1954 survey of 1945 medical graduates indicates that 27 per cent were engaged in full-time and an additional 16 per cent in part-time salaried occupations.<sup>90</sup> It is now estimated that "somewhat less than half" of all active doctors are on salary but that in one to two decades at least half of all doctors and a majority of the specialists will be drawing at least part-time salary checks.<sup>91</sup> Salaries are customary in the Armed Forces, the Veterans Administration, public health, industrial medicine and in research. They are increasing in teaching with the trend to full-time staff and are currently a matter of major controversy in hospital practice. Salaries are also common in private group practice clinics, both prepayment and fee-for-service, especially for younger staff members.

Another alternative to fee-for-service is payment by capitation—a flat annual or monthly sum for each patient for whom the doctor (or group) is responsible. This is the method used by HIP and a few state public assistance health programs.

A related development is the rapidly increasing standardization of rates, even among fee-for-service doctors. A recent state-wide survey of medical opinion by the Michigan State Medical Society revealed that nearly two-thirds of the doctors gave most weight to "the usual fee in the community" in setting their own fees. Only 21 per cent cited the doctor's own "evaluation of his professional ability" as the best criterion and only 14 per cent gave first place to the "economic potential of the patient."<sup>92</sup> The "medical Robin Hood" appears to be on the way out.

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<sup>90</sup> Weiskotten & Altenderfer, *Trends in Medical Practice*, JOUR. OF MED. EDUC., July 1956, Part 2, p. 78. The important influence of increased specialization upon the trend to salaries is seen by the fact that 91% of the full-time salaried graduates of 1945 were specialists. *Id.* at 81.

<sup>91</sup> Perrin, *Why More Doctors Are Going on Salary*, Medical Economics, Feb. 1957, pp. 226, 248. The AMERICAN MEDICAL DIRECTORY (1956 ed.) lists about 55,000 doctors on salary, i.e., about 27%. But the DIRECTORY includes many retired and inactive doctors in its overall count. It also appears that part-time salaried work and salaried assistants to private practitioners and groups are not counted.

<sup>92</sup> Medical Economics, Jan. 20, 1958, p. 30. The younger the doctor the more likely he was to charge standard fees. As a striking example of the change in approach to fees the survey reported that over 3/4 of the Michigan doctors would like to see Blue Shield fees tied to the cost of living. Medical Economics, Jan. 6, p. 98.

Another aspect of standardization is the increasing acceptance of fee schedules by doctors engaged on a contractual basis in various public and private insurance programs. Some such development was clearly inevitable if doctors were unwilling to work on salary or capitation plans and still wished to participate in governmental or insurance programs where the bills are paid by third parties and advance budgeting is indispensable. Until recently, most fee schedules have been private affairs between the contracting doctors and the agency or carrier. However, the establishment of "Medicare,"<sup>93</sup> the new program for dependents of service men, has resulted in fee schedules open for public inspection in almost all states. This is bound to influence other schedules.

The California Medical Association has developed, over the years, a Relative Value Schedule which attempts to relate the value of the various medical procedures to each other within four broad categories. The values are stated in abstract units only; no dollar value is attached. The schedule can and is being adapted—at varying price levels—to the California Medicare program, the state public assistance program and many private health insurance schemes. The Michigan Medical Society recently announced adoption of a "California-type" schedule for determining Blue Shield fees and the AMA is now working on a possible national relative value scale.

In short, doctors' fees are becoming both more uniform and more impersonal. That doctors themselves have not suffered as a result is clear from current income reports. Average net earnings among physicians in private practice in 1954 were over \$17,000, according to Medical Economics. The comparable figure for lawyers was \$10,294, according to a Department of Commerce study.<sup>94</sup> Doctors in combined practice do considerably better than average. Medical Economics provides the following estimates of median income in 1955: solo practitioners, \$15,028; doctors in two-man partnerships, \$19,966; those in larger partnerships or groups, \$21,460.<sup>95</sup>

### *C. Some Counter Trends*

Led by state and local medical societies, many of these new trends have been sharply challenged by important segments of the medical profession just as was the institution of hospital residencies half a century ago. A major

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<sup>93</sup> 70 STAT. 250 (1956), 37 U.S.C. §§ 401-23 (Supp. V, 1957). Under this law, which became effective Dec. 1956, the 2,000,000 dependents of U.S. servicemen are covered for most hospitalized illness (except chronic diseases) and minor out-patient surgery. It is financed by the Defense Dept. except for small charges to patients. Payments to hospitals are administered by the Blue Cross Comm. and Mutual of Omaha. Payments to physicians are made through Blue Shield plans, medical societies and Mutual of Omaha.

<sup>94</sup> Medical Economics, July 1957, p. 14. Until 1941, lawyers ranked ahead of doctors on the professional income ladder.

<sup>95</sup> March 1957, p. 122. Salaried doctors earned less: a median of \$12,059 compared with \$16,017 for all self-employed doctors. *Id.* at 118.

battle has been in progress for several years between the AMA and the American Hospital Association. The major issue at the moment involves the conditions of employment and remuneration of hospital radiologists, anesthesiologists and pathologists. The AMA wishes such specialists to be paid directly by the patient on a fee-for-service basis rather than by the hospital on salary or other contractual arrangement. Although the latter arrangement has been prevalent in nonprofit hospitals for years, it is now being condemned as the "corporate practice of medicine." The issue has been taken to attorneys general in a number of states for rulings under the old medical practice laws which were originally intended to outlaw quackery. Legal opinion has divided but the majority of recent rulings have favored the AMA position.<sup>96</sup>

The general counsel for the American Hospital Association has recently stated his view of this development: "The rationale of the adverse opinions, if they are correct, raises questions about many other aspects of the functioning of a modern hospital. At the least, this rationale obstructs certain organizational patterns that have been found widely useful; if it were carried to its seemingly logical conclusion, it could threaten the very existence of public and community hospitals as integrated institutions for the care of the sick."<sup>97</sup>

The AMA no longer opposes group practice, as such, even when combined with prepayment.<sup>98</sup> But the bitter opposition of state and local societies to "corporate medicine," "hospital groups," "lay-controlled health plans" and, in general, any plans which are not controlled by the societies themselves, has slowed down the development of group practice. In about half the states lay-controlled prepayment groups are virtually outlawed by

<sup>96</sup> According to Medical Economics, there have been 13 clear-cut legal decisions during the past decade. Of these, 9 favored the medical societies, 4 the hospitals. Taylor, *Who's Winning the War Over Corporate Practice?*, Medical Economics, Dec. 1957, p. 162. For more scholarly presentation of the two points of view, see AMA Bureau of Legal Medicine and Legislation, *A STUDY RELATING TO THE CORPORATE PRACTICE OF MEDICINE IN THE U.S.* (1956), and A. W. Willcox and others, *HOSPITALS AND THE CORPORATE PRACTICE OF MEDICINE* (AHA Hospital Monograph Series No. 1, 1957). Mr. Willcox appears cautiously optimistic as to the eventual outcome from the hospital point of view. In letters to the authors he stated, "I am inclined to believe that the 'trend' of opinions adverse to the hospitals ended some time ago . . . . Efforts are being made to secure attorney general opinions in New Jersey and Maryland, and if these materialize, we may know better which way the wind is blowing." (Jan. 14, 1958.) On Dec. 6, 1957, he wrote, "There is also the very real danger that medical societies may get further restrictive measures through state legislatures without adequate understanding of their effects. At the present time, I am inclined to be more concerned about the legislatures than about the courts."

<sup>97</sup> A. W. Willcox and others, *HOSPITALS AND THE CORPORATE PRACTICE OF MEDICINE* 1 (AHA Hospital Monograph Series No. 1, 1957).

<sup>98</sup> For the official history of AMA policy with respect to prepayment plans, see AMA COUNCIL ON MEDICAL SERVICE, *VOLUNTARY PREPAYMENT MEDICAL BENEFIT PLANS* (1957). For a critical review of AMA policy, see Comment, *The American Medical Association: Power, Purpose, and Politics in Organized Medicine*, 63 YALE L.J. 937, 976-96 (1954).



statute.<sup>99</sup> This situation has made it much more difficult for group-minded doctors to obtain the capital and professional and community support necessary to establish themselves. AMA opposition to various bills introduced in Congress providing long-term interest-free loans to nonprofit groups no doubt contributed to their defeat.

The opposition to the new institutional trends is shared by a good many patients. Those who have satisfactory relations with a family doctor are naturally loath to change. But even where this is not the case the extent of opposition, especially among lower-income workers, and in spite of general approval by top union leaders concerned with health and welfare issues, has come as a surprise to some.<sup>100</sup> Apparently the memory of poor medical care so often meted out in charity wards and free clinics of the past has created a psychological barrier to acceptance of the new type of group practice clinic.

Both types of opposition are likely to diminish in time. Both are expressions of a cultural lag which is gradually yielding to the combined forces of technology, demography and economics. Alanson Willcox concluded his study of "corporate practice" as follows: "[W]e are faced by two facts which are exceedingly difficult to reconcile. The first is that courts have said over and over again that corporate practice of medicine, dentistry and the like is illegal. The second is that, with the knowledge and acquiescence of all concerned, there are corporations in every state of the Union which are hiring physicians to practice medicine, and which are furnishing through physicians a considerable portion of the medical care of the American people . . . . This occurs in the main . . . not through any conscious winking at the law either by the participants or by law enforcement authorities, but from a genuine if unanalytical belief that these accepted practices are not illegal."<sup>101</sup> In such a conflict, it is clear which fact is likely to yield.<sup>102</sup>

<sup>99</sup> See Hansen, *Group Health Plans—A Twenty Year Legal Review*, 42 MINN. L. REV. 527, 531 (1958); and Hansen, *Laws Affecting Group Health Plans*, 35 IOWA L. REV. 209 (1950). Mr. Hansen, general counsel, Group Health Federation of Amer., claims that many of these laws are monopolistic and unconstitutional.

<sup>100</sup> For example, the proposal for an A.F.L. medical center in San Francisco, which seemed on the verge of adoption in 1952, was apparently defeated as much by the opposition or apathy of the members as by professional opposition.

<sup>101</sup> A. W. Willcox and others, *HOSPITALS AND THE CORPORATE PRACTICE OF MEDICINE* 58 (AHA Hospital Monograph Series No. 1, 1957). In a 1957 survey of 50 leading medical men, Medical Economics found that the majority agreed with this comment from a medical school dean: "There's been a tremendous drive to get the specialists off hospital payrolls. But it's had little effect. Very few hospitals have altered their arrangements because of the pressure. I doubt if many ever do. In the long run, the hospitals represent more people than the physicians." Perrin, *Why More Doctors Are Going on Salary*, Medical Economics, Feb. 1957, pp. 226, 242.

<sup>102</sup> On a closely related issue, the general counsel, Group Health Fed. of Amer., reviewing 20 years of law respecting group health plans, finds "the courts keeping pace" with the changes in medical economics. He alleges that "The apparent legal barriers to these plans, which so

The trend toward greater institutionalization of medicine is world-wide. In all countries, regardless of differing economic or political systems, medicine is changing from a private relationship between two individuals into a medico-social institution or, more precisely, into part of a great network of social welfare institutions which is making it possible to shift the emphasis from periodic cures to continuous health maintenance.

Leading medical schools have recognized this shift and are actively encouraging it. Dr. Willard Rappleye, dean of Columbia University's Faculty of Medicine, said in 1957: "The somewhat isolated, intensive, and scientific nature of medical education in the recent past is being rapidly changed because of universal recognition of the relationship of medicine in its social and public context . . . . Medical instruction today recognizes and is attempting to deal with the social, economic, emotional, and environmental elements of illness and incapacity in individuals."<sup>103</sup>

The trend is augmented by the scarcity of physicians. There is disagreement within the profession and among public authorities as to the extent of physician shortage but there can be no disagreement on the fact that the declining doctor-patient ratio<sup>104</sup> in a time of rapidly rising consumer demand and the resulting strategic sellers' market can be justified and continued only to the extent that the doctors increase their own productivity. And such an increase can only be accomplished through economies of scale resulting from optimum organization of the doctors' own services and optimum utilization of other health service personnel, *i.e.*, through institutional arrangements.

#### CONCLUSION

The implications of these trends for the future of voluntary health insurance are great, and will be examined in detail in the second installment of this article. A viable health insurance system must serve the interests of the providers of services as well as of consumers. In the area of hospital care this is clearly being achieved. But with respect to the provision of physicians' services, health insurance is caught in the middle of a great and

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recently seemed formidable, have been effectively removed." Hansen, *Group Health Plans—A Twenty Year Legal Review*, 42 MINN. L. REV. 527, 547 (1958). This, of course, does not mean all jurisdictions have accepted or acted upon this view.

<sup>103</sup> RAPPLEYE, *MEDICAL EDUCATION IN THE CHANGING WORLD* 15 (Colum. Univ. Press 1957). In another passage, Dr. Rappleye pointed out, "in the instruction itself the emphasis is placed increasingly on the longitudinal nature of disease and the changes that occur in the individual throughout his entire life span rather than on the occasional acute illness or episode of disability." *Id.* at 7.

<sup>104</sup> In 1909, there were 149 physicians per 100,000 population; in 1952, only 133. 3 BUILDING AMERICA'S HEALTH 135. In 1958, according to Dr. Grayson Kirk, president of Columbia Univ., the ratio is 130 to 100,000. N.Y. Times, Mar. 27, 1958, p. 29. Dr. Kirk and many leading medical educators expect the present ratio to decrease. For a recent survey of this problem, see M. Clark, *Nation Needs Physicians to Meet Population Rise*, N.Y. Times, Mar. 3, 1958, p. 1.

difficult transition. If it is to operate satisfactorily it cannot impose upon doctors organizational arrangements to which the majority are opposed. This has been a persuasive argument of the AMA leadership against comprehensive prepayment plans or other forms of insurance which seemed to threaten traditional fee-for-service solo practice.

If, however, it should develop that, quite aside from the influence of insurance, fee-for-service solo practice is no longer the dominant form of medical organization, the argument will be turned around. Indeed, some critics of the prevailing indemnity insurance pattern are already saying as much. A vice-president of the United Automobile Workers, one of the most influential labor groups in the health and welfare field, said recently that health insurance is trying to turn the clock back and "superimpose the modern concept of prepayment on an archaic system of solo practice."<sup>105</sup>

It is still premature to call solo, fee-for-service practice "archaic." Nor is there any inherent reason why this type of practice, if adequately supported by hospital services and informal professional cooperation and tempered by fee schedules and a sense of responsibility, cannot be continued under comprehensive health insurance as the example of Windsor Medical Services indicates. But all the signs suggest that these two traditional characteristics of United States medical practice are gradually moving into a minority position—a trend which cannot be ignored in future health insurance arrangements. For if health insurance is to meet the growing demand for "comprehensive care" it must make the most efficient use of the potential for increased productivity and improved quality implicit in these technological and organizational trends. Since the continued vitality of health insurance is now equally essential to the financial security of the providers and the consumers of service, pressure for greater freedom and experimentation along these lines is almost bound to increase.

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<sup>105</sup> L. Woodcock, quoted in Croarman, *Is Labor Through with Private Medicine?*, Medical Economics, Oct. 1957, pp. 174, 180-81.