The out-patient department of New York's Presbyterian Hospital. Would these people get better or worse care under a national health program?

JACK MANNING

Do You Really Want Socialized Medicine?

By STEVEN M. SPENCER

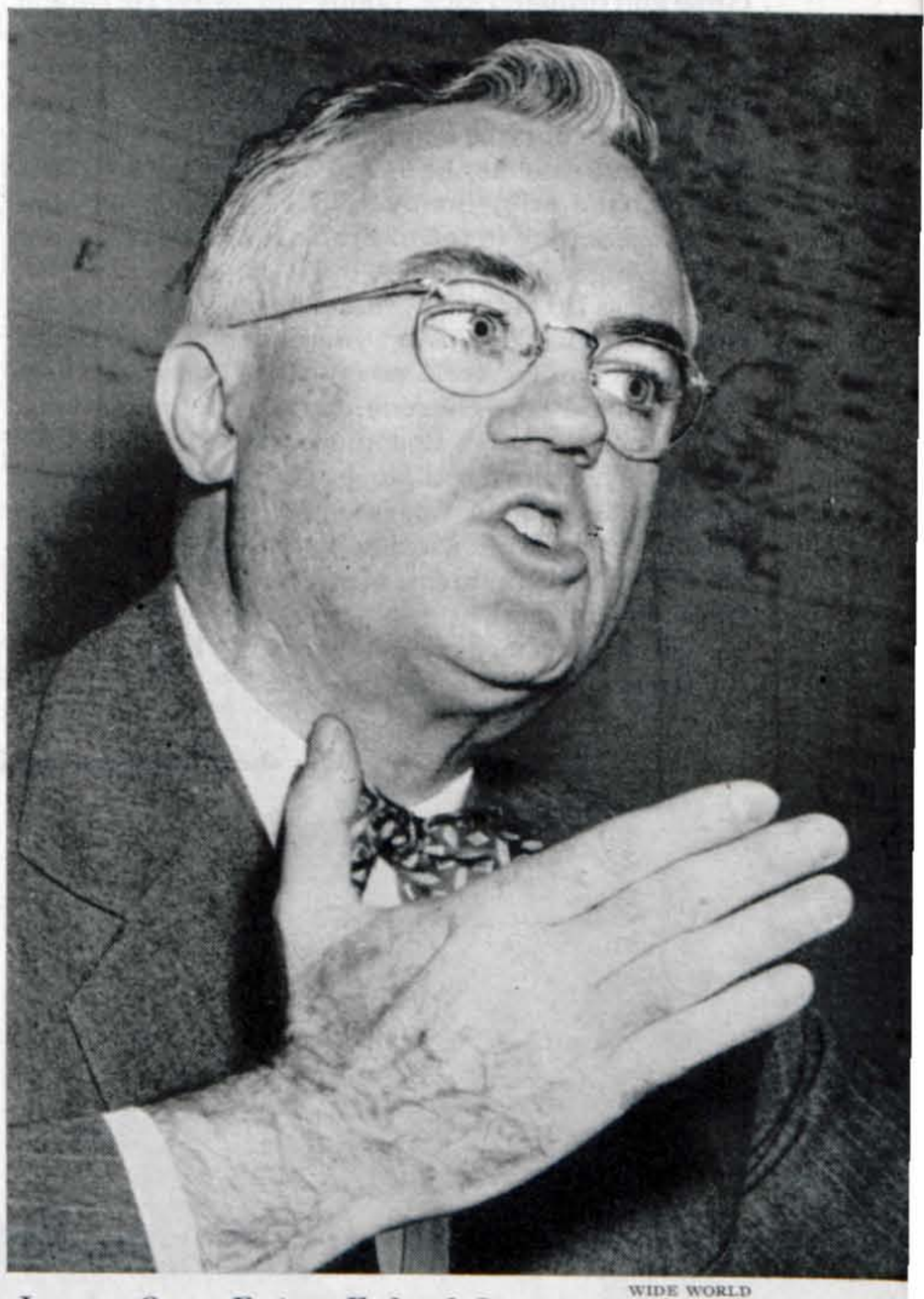
Rarely are you asked to make up your mind on an issue that so deeply affects your personal welfare. Here is what you need to know before deciding on the Truman proposal.

FOR the eighth time in ten years the American people are being urged to let the Government pay their doctors for them, with money collected from the American people. The system is called compulsory health insurance, and the theory is that everybody who doesn't have enough medical care today will surely have it tomorrow, because the Government will see to it that he does.

Between theory and practice there is a tremendous gap, much of which is currently being filled with arguments. Many of them fall in a familiar groove, but they are pitched this time against a more substantial background than heretofore—namely, the actual experience of 48,000,000 residents of Great Britain under a comprehensive National Health Service. The scheme entitles everyone in Britain, visitors as well as citizens, to all medical, dental and hospital care at the expense of the taxpayers.

Curiously, Britain is being called to give testimony for both sides of the American controversy. Many of those who want compulsory health insurance cite the British plan as a shining example for us to follow. Their opponents, including the American Medical Association, point to the same program as a warning of dire things to come if we adopt any Government-directed system and propose, instead, an extension of voluntary health insurance, with financial help from state and Federal governments.

What is the story? Should Britain's eleven months of nationalized medicine— *(Continued on Page 133)*



WIDE WORLD

Lawyer Oscar Ewing, Federal Security Administrator, is the principal Government salesman of the compulsory-health-insurance idea in the U.S.

DO YOU REALLY WANT SOCIALIZED MEDICINE?

(Continued from Page 29)

socialized if you use the broad definition of that term—cause us to embrace or reject the compulsory plan so insistently advanced by President Truman, Federal Security Administrator Oscar R. Ewing and the Wagner-Murray-Dingell group in Congress? In this article we shall look for an answer by examining the Administration's health-insurance plan in the light of the British experience.

The explanation for the two-way character of the British evidence is that, where there are as many people of intelligence and good will as one finds in England, no plan for the care of the sick will be a 100 per cent failure—at least not at first. Most people are willing to give it a sporting chance. Even the British doctors, while swearing under their breath—and sometimes audibly—at Minister of Health Aneurin Bevan and the scheme which he and Parliament pushed through over their opposition, are trying sincerely to make it function. And certainly the majority of the working people—whose purchasing power has for years been much below that of Americans at comparable jobs—welcome a form of medical care supported mainly by taxes on the middle- and upper-income groups.

Yet it is highly significant that nearly everyone with whom I talked in England had some reservations about the scheme. People felt that too many were abusing it and thus jamming the traffic in the doctors' offices, that many physicians were being overworked and underpaid, that dentists and eyeglass dispensers were making a killing, that the administrative machinery was cumbersome, slow and inefficient. Even one of the government's own regional officers remarked that "most people would not be so mad as to take over such a large thing all at once."

The temptation to buy the whole package at one time is very great in this period of increasing dependence on government. In fact, the first danger in any proposal for government medicine lies in the ease with which it can be glamorized. Like the body-building courses that come with a pair of twenty-five-pound dumbbells, it looks magnificent on paper. Unfortunately, the result is usually far short of the pictorial promise in the advertisement. The dumbbell system has one advantage, though. If, after a few weeks, you are dissatisfied with your rate of deltoid development, you can stow the dumbbells in the attic and forget them. State medicine is not so easily shucked off, once you have installed it.

A good many of the British people admit they bought Bevan's system a bit too hastily, and they now confess to a feeling of disillusionment. They had been won over by the bright promises of everything for everybody. Now that the scheme has been in operation almost a year, their enthusiasm has dimmed.

Three North of England women expressed this reaction in strikingly similar terms. Said a hospital superintendent, "I was for the plan, but this transitional period sometimes makes you wonder if it is worth while." Then she added, "But I do think it will work out eventually."

A miller's wife, formerly a nurse, remarked, "I thought beforehand that nationalization of the hospitals would be good, but now that I've seen how it works out, I think I was wrong. . . . The county hospitals are operating ten automobiles where they were running only one before. . . . Everybody feels he must get what he can out of the government before someone else does."

And a woman doctor, brushing a wisp of blond hair out of her eyes as she signed a sheaf of certificates and orders, confessed, "I was for the plan, but now we family doctors seem to be in danger of becoming simply form fillers and traffic officers, shunting people to this hospital or that specialist."

Some of the British criticism of the National Health Service is bound up in a growing dislike of the whole idea of the welfare state, in which food, housing, fuel and now medical care are at least partially provided by the government.

One of England's leading medical scientists, head of an important government council, feels so strongly on this point that he told me, "If I were a young man in England today, I would get out and go somewhere else. I don't object to seeing that the poor get enough to eat," he said, "but why should I be taxed to the limit to put bread in the mouth of the employed worker, who should work hard enough and be paid enough so that he can buy his own food without heavy subsidies?" The comment is frequently heard in England that so much subsidizing is destroying the people's initiative.

While the British health program differs in details from the compulsory-health-insurance measure of Senators Robert F. Wagner and James E. Murray, and Congressman John Dingell and their cosponsors, the two plans are cut on the same basic pattern. Both spread the wings of government-directed medicine over all or nearly all of the population. Both lean heavily on central government authority. And both are compulsory in that all wage earners and taxpayers must pay for the services, whether or not they approve them or make use of them.

The scope of the new Wagner-Murray-Dingell bill is not quite so broad as that of Bevan's plan, since the former would cover only those under Social Security, with a few additional categories. But the trend is to broaden Social Security to take in almost everyone. "We aim to have everyone who is the head of a family become taxable," explains Mr. Dingell, "so that he and all his dependents under eighteen would be entitled to benefits. . . . Why, this is the most liberal proposition in the world."

Many of Mr. Dingell's opponents think his bill is far too liberal. Why, they ask, should tax-supported medical care be offered everyone, the $10,000-a-year man as well as the family getting along on $1500? The coverage of government medicine is one of the crucial issues of the whole controversy. Both sides agree that no one who needs medical care should be denied it because he is unable to pay. The opponents of compulsory insurance maintain that it is in the American tradition that those who are able to care for themselves and their families should not lean on government for help. The Wagner-Murray-Dingell group maintain it is too hard to determine who is able to care for himself and who isn't, and that the easiest and fairest way is to make medical care freely available to everyone on the basis of compulsory wage deductions.

Mr. Dingell recalls that his own family lacked means for adequate medical care when he was a boy. "I contracted diphtheria," he said, "at a time when it cost twenty-five dollars a shot for antitoxin. My family couldn't afford that, and I guess I was one of the very few who pulled through without it."

He declares that he has seen people refused admission to hospitals because they had no money, and he cites the case of a man brought in from the street in Detroit with third-degree burns. "Because no one, including the policeman who brought him in, could insure the fellow's bill," Dingell said, "the patient was turned away from one hospital and had to be carried clear across town to the city receiving hospital. Under a system in which every hospital knew the Government would pay every patient's bill, this would not have happened."

There are doubtless occasional instances of this kind under our present system. Usually they can be blamed on the stupidity or callousness of hospital clerks or attendants. But can a compulsory health insurance insure against stupidity, callousness, poor judgment or other human failures? It certainly cannot immediately guarantee a hospital bed for everyone who needs it. In spite of pay rises which have brought more nurses into the hospitals of England, the increased demand for hospitalization has made the shortage more acute since the National Health Service began. There are still 60,000 beds closed by lack of staff. In February the London Emergency Bed Service had 185 calls a day for beds, and each day about fifty persons had to be turned down. The London medical committee, in fact, expressed concern over delay in admitting patients with acute disorders and worried about reports of "many patients who have died, but whose lives might have been saved if energetic action had been taken." Serious illness was no more prevalent than before the Minister of Health took over the hospitals, but more patients were being referred for admission and had thus crowded the facilities.

And why are there increased referrals to the hospitals? One reason is that the general practitioner is run ragged by people with minor complaints, requests for certificates, prescription refills and permits. When a really sick person turns up, the doctor is so pressed for time that he often follows the simplest course and passes the patient along to the hospital, perhaps without even a tentative diagnosis.

A specialist at London's famous St. Bartholomew's Hospital told me, "Many people are coming to our outpatient department who, under the old system, would have and should have been handled by a general practitioner. And often we get only two or three lines from the family doctor on the patient's referral slip, or just the phrase, 'Please see.'"

A similar clogging of the medical machinery would almost certainly occur in this country if the Government made medical service freely available to everybody, without any brake on those who might be inclined to abuse or overuse it.

Both Mr. Bevan in England and Mr. Ewing in the United States view the increased demand occasioned by a state medical service as proof of its need. Mr. Ewing has claimed that compulsory health insurance would bring "unrecognized, hidden or neglected illness out into the open by making medical care more easily available." But the average doctor in England today has little opportunity to look for the hidden illness or identify the vague symptom. Lord Horder, physician to the King of England and leader of an organized opposition to the health scheme, points out that "the essence of good doctoring is diagnosis, and diagnosis calls for time and a close-up with the patient, both of which are denied to thousands of practitioners here." He says the doctors' time has been spread so thin that the standard of medicine in his country is falling.

What about the cost of compulsory health insurance? When Mr. Ewing predicts that the expenditures for this vast program "would represent new burdens on the economy or the contributors only to a limited extent," he would seem to be either kidding the public or using an unlimited definition of "limited." Judging by the experience of Britain and other countries, government medicine not only costs far more than private medicine but becomes increasingly more expensive as time goes on and the package gets bigger.

The Administration spokesmen for compulsory insurance usually dwell on the wage deduction as its main means of support. This would be a 3 per cent tax—divided equally between employee and employer—on wages and salaries up to $4800, an addition to the present 2 per cent Social Security tax for old-age and survivors' insurance. The self-employed would chip in the full 3 per cent. But the Administration bill itself would tap the Treasury for a lot more.

"You'll forgive me if I leave—I'm getting on in years."

It would permit a direct appropriation equivalent to 1 per cent of aggregate wages under $4800 to set up a reserve fund. It would authorize another sum to cover the cost of dental services and home nursing, plus "any further sums required to meet expenditures to carry out this title." In other words, the funnel is wide open at the top. American Medical Association critics estimate the compulsory-insurance program would cost ten or fifteen billion a year, or two to three times what the country is presently paying for medical care.

Even if we are willing to pay for so grandiose a medical program, it would be impossible, or at least extremely difficult, to provide more medical care with the present number of doctors—about 170,000 active physicians. The Truman-Ewing intention is to allow a three-year "tooling-up" period before putting the scheme into operation, and during this time to start increasing the doctor supply—aiming at a 50 per cent gain by 1960—through Federal aid to medical schools and students. In their desire to expand medical education they have support from nearly all groups. But if Government health insurance is in the offing, will it be possible to recruit the high-caliber young men that the profession needs?

In England as well as in America the medical profession has objected to focusing authority in a government officer who may have had no previous experience in medical or health matters. Both the British act and the Murray-Dingell bill set up regional or local boards to deal directly with the doctors, and there is medical representation on these boards. But major decisions are made at the top. In Britain, the Minister of Health, Aneurin Bevan, whose background is labor disputes and not medicine, exerts tremendous power through appointments and the authority to make regulations. He is also the court of final appeal when dismissal of a doctor is sought for "inefficiency" or other reasons—a clause of the act which the physicians fought bitterly but vainly.

Commander in chief of the Government medical system outlined by the new Wagner-Murray-Dingell bill would be the Federal Security Administrator, currently Oscar R. Ewing, a lawyer and the principal Government salesman of the compulsory-insurance idea. The bill sets up a National Health Insurance Board of five members. But it states that all functions of the board "shall be administered by the board *under the direction and supervision* of the Federal Security Administrator," (italics ours). The functions include the making of "all regulations and standards specifically authorized" by the bill "and such other regulations not inconsistent with this title as may be necessary." In other words, the Federal Security Administrator would be the boss, with sweeping powers to regulate and control.

In making regulations, the Federal Security Administrator could consult with a National Advisory Medical Council of sixteen members. But the name is somewhat misleading, as only six of the sixteen must be "individuals who are outstanding in the medical or other professions concerned with the provision of services." And all sixteen would be appointed by the administrator, an arrangement which could permit the council to become nothing more than a rubber stamp for the Administration's decisions. Furthermore, the chairman of the main National Health Insurance Board would serve as chairman ex officio of the Advisory Council.

Each state would develop its own plan of operation, to be carried out under a new or an existing state agency, such as a department of health or welfare. The state agency would make agreements with individual medical and dental practitioners, with hospitals or with voluntary-health-insurance groups, to supply medical and hospital service. The state would be divided into local health areas, each with an administrative officer or committee appointed by the state agency. Doctors and dentists in each local area would be given their choice, to be decided by a majority vote, of three methods of payment: (1) a fee for service based on a fee schedule, (2) a per capita basis—an annual sum for each patient on the doctor's list, as under the English system for general practitioners—or (3) whole or part-time salary. The bill also stipulates that in setting the rates of payment "consideration shall be given to degree of specialization and to the skill, experience and responsibility involved in rendering the service." This is, of course, only a statement of aims, and to work out a scheme that would recognize variations in skill and experience would be one of the most difficult tasks of the entire program, as the British have discovered.

This organization chart may look neat and simple on paper. But it is the framework for a huge, sprawling pyramid of administrative officials and committees, mainly nonmedical people, who will number in the thousands. And it is this potential bureaucracy—vulnerable to political pressure and characterized by billions of forms to fill out and file, as under OPA—which the opponents of compulsory health insurance see as a threat to the independence and initiative of the physician and to the quality of medical care.

While one cannot judge the whole British system by the creaks and squawks from scattered sections of it, there are certainly many reports of friction between the doctors and the lay boards, some of whose members are unfamiliar with and even antagonistic toward the physicians' problems. I was told of a Regional Hospital Board in Yorkshire which, in staffing hospitals, selected as a surgeon a man who had never done any surgery, and which didn't even have on its lists the name of one of the most experienced men in the community. In fairness to the board, it must be reported that it finally yielded to the organized protests of the doctors of the community and permitted them, in effect, to choose the staffs.

Not all boards have been as reasonable. One lay member, when informed that the doctors' authority on management matters extended only to making recommendations, replied with some vigor, "That's fine. Then we can veto them."

In the long battle against the rise of socialized medicine in this country, the burden of defense has been carried by the American Medical Association and its fast-talking editor, Dr. Morris Fishbein, who has a beat-'em-down technique in debate. In spite of Doctor Fishbein's dynamic delivery, the AMA has often defended the status quo instead of actively seeking an alternative solution. The organization has in the past opposed or given a cool reception to almost every development designed to solve the problem of the distribution and cost of medical care—including many which have turned out to be beneficial. Hospital- and medical-care insurance plans struggled through their early growth without the benefit of the AMA blessing. Group practice, in which

a partnership or team of general practitioners and specialists provide complete medical care, was not given general encouragement, on the ground that some groups were tainted with commercialism.

Much of this conservatism in medical economics is understandable in a profession which must safeguard the public from premature and immature "cures," and which must handle new treatments and drugs with caution until they have been proved safe and effective. But it has often worked to the profession's disadvantage. Plain-spoken Dr. Paul R. Hawley, who overhauled the Veterans Administration medical department a few years ago and who now heads the Blue Cross-Blue Shield Commission, summed up the reaction of more liberal physicians to this static defense in a recent speech: "I am afraid that a large part of the public has come to expect organized medicine to oppose every suggestion tending to solve this problem of the cost of medical care."

Now, however, organized medicine is at last definitely pushing voluntary health insurance as the best defense against the compulsory Government-directed variety and as an answer to a real need. In a refreshingly frank editorial, the Journal of the American Medical Association recently stated: "No one asserts or claims that leadership in American medicine has not on occasion made mistakes. . . . No one claims even that the House of Delegates (representative governing body of the AMA) has not on occasion been slow to change its point of view. But medical leadership does claim that physicians must have evidence of the desirability of new methods and new technics in the delivery of medical service before it can act for the medical profession of the nation in accepting any proposal. Indeed, the great hazard of such legislation as that which perpetrated the National Health Act on the people of Great Britain is the difficulty of eliminating such a procedure even after its faults have become horribly obvious."

To carry its arguments to the entire population, through speeches, posters, movies and millions of pamphlets, the AMA is now raising a "war chest" of about $3,500,000 through a twenty-five-dollars-per-member assessment. (There are 140,000 members.) The AMA's new "battle plan," prepared with the help of its newly retained Chicago public-relations consultants, Clem Whitaker and Miss Leone Baxter, urges organized medicine to "get off the defensive" and to "conduct an affirmative program of education," including "active co-operation with the prepaid medical and hospital plans and the accident and health insurance companies, in an all-out drive to provide the American people with voluntary-health-insurance coverage."

Most of the AMA's state societies, during the past several years, have established their own prepayment-medical-care programs. These Blue Shield plans, as they are called, are now operating in forty-two states and the District of Columbia, and cover a total of about 10,000,000 subscribers and dependents. Annual premiums range from twenty-five to fifty dollars per family, and the plans pay for surgical and often for medical care, in cases requiring hospitalization. They are usually sold by the Blue Cross hospital-insurance organizations, which now have a total enrollment of about 31,000,000.

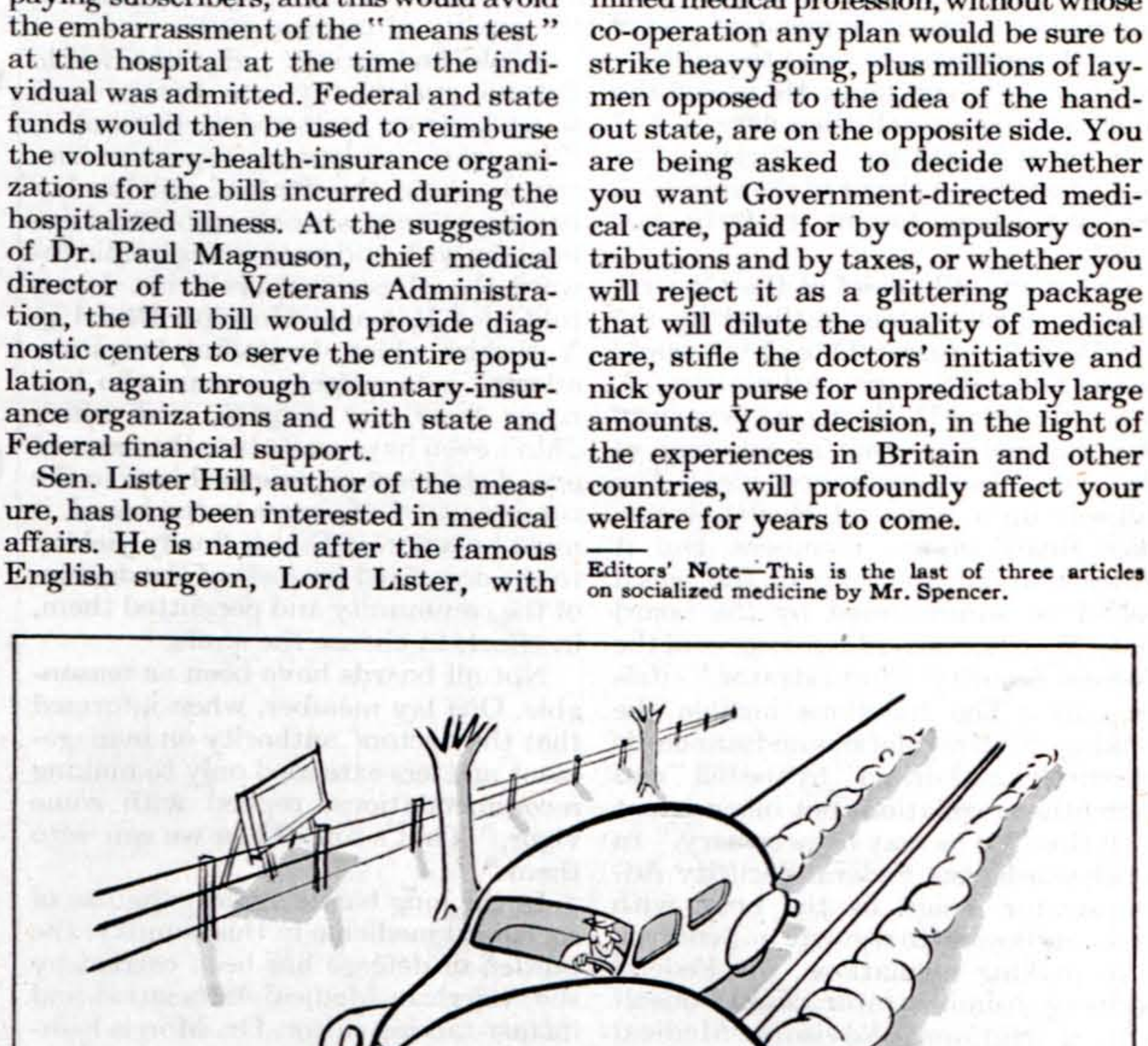
Advocates of compulsory health insurance object that the voluntary surgical and medical insurance plans cover only the hospitalized cases and do not pay for home and office calls. This is true in most plans. But medical bills incurred during hospital illness make up half the nation's outlay for medical care and, for most families, it is the tough half because it comes unexpectedly and in big chunks. It is these big bills which wreck the family budget, but it is the oft-repeated small bills for office and home calls which can wreck either voluntary or compulsory insurance schemes. The reason for this is that when payment of a fixed annual fee entitles people to call the doctor as many times as they wish, the system is abused. The insurance company, paying the doctor for each visit, finds its funds drawn on too heavily. The home and office calls, without restriction on number, are not, in other words, a predictable and, therefore, an insurable risk. The Michigan Medical Service, one of the first state-society plans, started to cover these calls under its annual premium, but almost went broke and had to write in restrictions.

A second important objection to voluntary health insurance is that the poorer people cannot afford the premiums and therefore are not covered. Dr. Gilson Colby Engel, a Philadelphia surgeon and president of the Medical Society of Pennsylvania, recently proposed a plan which would correct this deficiency and which has now become a key feature of the bill introduced by Sen. Lister Hill, Democrat, of Alabama. Membership cards in voluntary hospital and health-insurance organizations would be issued to those certified by local welfare authorities as requiring financial assistance. The cards would be identical with those carried by full-paying subscribers, and this would avoid the embarrassment of the "means test" at the hospital at the time the individual was admitted. Federal and state funds would then be used to reimburse the voluntary-health-insurance organizations for the bills incurred during the hospitalized illness. At the suggestion of Dr. Paul Magnuson, chief medical director of the Veterans Administration, the Hill bill would provide diagnostic centers to serve the entire population, again through voluntary-insurance organizations and with state and Federal financial support.

Sen. Lister Hill, author of the measure, has long been interested in medical affairs. He is named after the famous English surgeon, Lord Lister, with whom his father, the late Dr. Luther L. Hill, of Montgomery, Alabama, studied as a young man. Senators Hill and Harold Burton, of Ohio (now a Supreme Court justice), sponsored the Hill-Burton Hospital Survey and Construction Act, to provide Federal grants for hospitals throughout the country. More than 700 projects have been approved. Hill's four cosponsors on the present health bill are Senators George D. Aiken, of Vermont, Garrett L. Withers, of Kentucky, Wayne Morse, of Oregon, and Herbert R. O'Conor, of Maryland. All but Mr. O'Conor are members of the Senate Committee on Labor and Public Welfare, which will consider this bill, the Administration measure and the new health bill introduced by Sen. Robert Taft. The Taft bill would establish a National Health Agency to be headed by a doctor and to take in the Public Health Service, the Food and Drug Administration and other health functions now performed by Ewing's Federal Security Administration. It would also make grants to the states for assisting in the payment of medical-care costs for those unable to pay their own, in a manner somewhat similar to that proposed in the Hill bill. Taft's cosponsors are Senators H. Alexander Smith, of New Jersey, and Forrest C. Donnell, of Missouri. All three are on the Labor and Public Welfare Committee, seven of whose thirteen members are thus sponsoring voluntary rather than compulsory health insurance measures.

This, then, is where we stand today. The lines are more sharply drawn than ever before. Politically powerful groups in the Administration and in Congress are determined to push Government medicine through. An equally determined medical profession, without whose co-operation any plan would be sure to strike heavy going, plus millions of laymen opposed to the idea of the hand-out state, are on the opposite side. You are being asked to decide whether you want Government-directed medical care, paid for by compulsory contributions and by taxes, or whether you will reject it as a glittering package that will dilute the quality of medical care, stifle the doctors' initiative and nick your purse for unpredictably large amounts. Your decision, in the light of the experiences in Britain and other countries, will profoundly affect your welfare for years to come.

Editors' Note—This is the last of three articles on socialized medicine by Mr. Spencer.



"Why don't you just shut your eyes, Otis, and enjoy the ride?"