Who should pay the doctor bills?. [1936?]

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WHO SHOULD PAY THE DOCTOR BILLS?

Henry L. Ewbank
Martin P. Andersen

PUBLIC DISCUSSION OUTLINE

DEBATE QUESTION

Resolved: That Wisconsin should have a system of complete medical service available to all citizens at public expense.

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"Because large groups of the population seem unable to provide themselves with adequate medical services, the problem was of major importance five years ago. It is of vastly more importance now, because of the change in the economic situation." President Franklin D. Roosevelt.

The Problem of Medical Care. The past decade has witnessed an increasing number of attempts on the part of the American people to adjust their social order to meet new and changing economic conditions--to provide greater social security. An important phase of this problem of social security is the matter of public and individual health. We have come to accept the fact that (1) the health of every individual is a social concern and responsibility; and (2) that adequate medical care must be provided inespective of the ability of the individual to provide for it. At the same time we cannot overlook the necessity of providing economic security for the medical profession whose function it is to provide this medical care.

The problem for consideration, therefore, is to determine if the costs of medical care can be readjusted to provide a greater amount of health security for the people and economic security for the doctor, nurse, and dentist. We should first, however, have a clear understanding of the economic and social factors which have brought this demand for a readjustment before we can intelligently determine which of the proposed solutions is most desirable.

BACKGROUND MATERIAL*

Extent of the Medical Problem. The annual bill of the American people for medical service is three and one-half billion dollars, four per cent of our national income. One and one-half million people earn their livelihood in the service of providing medical care. Six billion dollars are invested in plant and equipment. Whether measured in terms of expenditures, invested capital or personnel, as an industry medical service ranks fifth or sixth.

Source of all Medical Expenditures.

Private persons	79%
Taxation of various governmental units	14%
Philanthropy	5%
Industry	2%

How the Medical Dollar is Spent.

Physicians in private practice	29.9¢
Hospitals	23.4¢
Medicine	18.2¢
Dentists	12.2¢
Nurses	5.5¢
Cultists	3.4¢
All Others	4.2¢

* Debate Handbook on State Medicine, prepared for the Committee on Interstate Debating of the National University Extension Association, Sept. 1, 1935. Article by Professor Brooks Quimby, Director of Debating at Bates College, Lewiston, Maine. pp 10-14.

Those expenditures are not considered excessive--only thirty dollars per capita and one hundred twenty-three dollars per family. The trouble lies in many inequalities. Were the whole medical bill of the nation financed by equal contributions from each family, adequate medical care could be furnished, in the opinion of the Committee on the Costs of Medical Care, for thirty-six dollars per person, with ten dollars and seventy cents of this amount going for dentistry.

At present the costs are not equitably distributed but bear so heavily on several million families that they are able to pay less than fifty percent of their medical bills. Many treatments are given only through the charity of physicians and hospitals, or as poor relief. The burden of illness falls unevenly; in a normal year 47.1% of the people have no illnesses.

How the Costs of Illnesses Vary.

Cold or minor digestive disturbance	$ 6.00
Pneumonia	59.00
Appendicitis	169.00

Inequalities in Expenditures for Medical Care. In any given year, 10% of the families are responsible for 41% of the expenditures for medical attention. The greater the income of a group of people, the greater their expenditures for medical care. But in the same income group only 10% to 15% of the families expend the group average and those in larger communities pay more than those in the same income class in small communities.

Partly, at least, as the result of this unequal burden on individual families, many people are not receiving proper care. Not one person in ten has an adequate medical examination each year. Sixty-five percent to 95% of our school children have physical defects which have been untended. Thousands seek aid from various cults, and over a half billion dollars is spent for patent medicines. Out of the thirty dollars per capita expended for all medical service, only one dollar goes for prevention.

Other Inequalities in the Problem of Medical Care. Many smaller communities do not have sufficient people or income to support a physician, while Chicago has physicians on its relief roll. Hospitals are ill-distributed. In cities, because of the lack of organization of the profession, there is a helplessness and incapacity to search out the medical service needed from the bewildering array offered.

The physician is not profiting from the patient's financial burden; far from it. He does an excessive amount of charitable work, and he leaves many accounts unsettled. The hazard of inequality imperils his income. Forty percent of his gross income goes to professional expenses. If we consider twenty-five hundred dollars as a fair income, even in the prosperous days of 1929, 33% of the physicians and 22% of the dentists had less than that amount. Eighteen percent of the physicians and 8% of the dentists had incomes of less than fifteen hundred dollars. For every physician who received more than ten thousand dollars, there were two who received less than twenty-five hundred dollars.

Different Views As to What To Do. With the impossibility of any one family budgeting illness and with the resulting lack of adequate medical care, the main question is clear; what can be done to enable every person to have adequate medical care at a cost within his means?

There are several schools of thought. The minority of the Committee on the Costs of Medical Care took a stand which has the endorsement of many leaders in the American Medical Association. They favor the relief of the medical profession of the care of the indigent by the substitution of government financing, but would have government competition in the practice of medicine discontinued except for the indigent, the army and navy, the public health service, and the care of certain diseases such as insanity and tuberculosis. They favor the restoration of the general practitioner to the central place in medical practice and oppose corporate practice of medicine. The supporters of this point of view contemplate a continuation of the individual fee-for-service basis with the sliding scale of payment by which the physician, as an independent entrepreneur, collects from those who can afford it a sufficiently large fee to balance the modest payments of those with lower incomes. In general, they would have no sweeping changes in the present economic organization of medicine, but would favor raising the income level to meet the demands of medical service.

The majority of the Committee on the Costs of Medical Care urge experimentation with various forms of group practice and group payment for medical services. Such experimentation is now being promoted by the Julius Rosenwald Fund, Milbank Memorial Fund and Twentieth Century Fund. The majority report stresses the evolutionary processes now going on in medical practice, in view of changing social and economic conditions, and favors various experiments of a group nature which are being attempted in this country. It declares "that medical service, both preventive and therapeutic, should be furnished largely by organized groups of physicians, dentists, nurses, pharmacists and other associated personnel."

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

Followers of this school of thought usually contemplate a voluntary form of health insurance under which a group of people contract with a medical group to receive specified medical service as needed, in return for the payment of a fixed annual sum. Plans of this type, perhaps best known in the form of the Brattleboro, Vermont, Group Insurance, have sprung up rapidly in various sections of the country and have the backing of significant individuals and organizations. The State Medical Society of California issued a pamphlet in 1933 endorsing the insurance principle and proposing a plan for that state under the direction of the county medical associations. The American Hospital Association and the American College of Surgeons have outlined models for such group payment plans. The group practice idea has been steadily growing with an increase in patients in already established clinics of from 50% to 100% since 1930.

A smaller group within the majority of the Committee on the Costs of Medical Care recommend that health insurance should be compulsory and not voluntary. The minority, though opposed to health insurance in any form, declared that compulsory insurance would be preferable to voluntary. The fact that voluntary schemes abroad have usually developed into a compulsory form give weight to this point of view. It may be that the majority felt that a period of experimentation with local, voluntary projects was necessary in this country before a national compulsory system suited to our needs, traditions and institutions could be worked out.

Conditions in Foreign Countries. Twenty-five European countries have some provision for insurance against illness. The German and British systems are best known. The former is more nearly state medicine, while the British system is noteworthy in that the insured may select his physician from a "panel" of physicians in his community who have agreed to perform services for the fund under the conditions and fees which the fund has specified. The appeal in a compulsory insurance scheme lies in the wide acceptance of this method of distribution of risk and the appreciation that much of our present difficulty is due to unequal incidence of sickness and cost of medical care. Added to this is the fact that the wider the distribution of the risk by the enrollment of all employed workers, for example, the more nearly will the burden on each family approach the average set by the Committee on the Costs of Medical Care at thirty-six dollars. From health insurance, it is but a short step to the more radical proposals of "state" or "socialized" medicine. In the former, the state finances and controls medicine as it now finances and controls education. Medical service is offered to any who care to avail themselves of it and the expenses are borne from taxation. All institutions and equipment are state owned and the personnel are governmental employees. In the latter type of service the state assumes the financial responsibility but the practitioners may be private physicians with a panel system like that in England.

Health insurance as practiced in Germany, for example, has many of the characteristics of socialized medicine. In the province of Saskatchewan, legal provision has been made for isolated rural communities to hire a resident physician out of tax funds. In some American communities, the more informal method of subsidizing the physician who will agree to take up his residence in an isolated community, or one so small that individual fees would be inadequate for the support of a resident physician, has been used to some extent; but no complete system of state medicine is in vogue in the United States. The Russian system of state medicine is the most conspicuous example of an attempt to supply complete medical service as a state function comparable to education.

There will be those who view with alarm what they consider an attack on one of our oldest and most respected professions. They will look askance at any infringement of the government on the rights of the individual practitioner to carry on his profession or the individual patient to select such service as he may wish. Others will accept the need for more cooperative action, but hesitate to allow the state, with its dangers of political control, bureaucracy and inefficiency, to be in a position to dictate to all the people regarding their personal health and habits. They will recall the ease with which the Nazis forced naturopathy on Germany, and will seek for a solution

in group movements of a voluntary nature. There will be those who will stress the present problem as one of lack of distribution of risk and expense, and consider it an ideal field for the operation of the insurance principle which is likely to loom large in legislative halls this winter. Finally, there will be those who have no patience with the slow evolution of voluntary methods and whose social philosophy will call for complete assumption by the state of the function of providing medical service along with education.

THE PROBLEM AS IT AFFECTS THE PATIENT

Ratio of Physicians to Total Population.

Sweden	one to 2890
France	one to 1690
England	one to 1490
United States	one to 780
New York	one to 620
California	one to 571
South Carolina	one to 1431

Committee on the Costs of Medical Care
Vol. 27, pp 195-286.

Communities Without Physicians. In rural communities the conditions are even worse, many having no physicians at all. In a survey of 227 villages in twenty-one states the following conditions were disclosed:

East Brewton, Mass	1002 persons and no doctor.
Columbia Heights, Minn	5613 persons and no doctor.
Northbridge, Mass	9713 persons and one doctor.
Flint, Mich	156,492 persons and 154 doctors.

"Location Survey," Medical Economics,
May and June, 1935.

Failure to Receive Medical Care. The number of individuals medically uncared for varies from 17% to 47% according to the income levels of the respective family groups.

Family Income	Percentage receiving no Medical Care
Under $1200	46.16%
1200-2000	42.2%
2000-3000	37.3%
3000-5000	33.5%
Over 5000	14% to 24%
All Incomes	38.2%

Committee on the Costs of Medical Care,
Vol. 28, p.9. Vol. 27, p.69-70.

In 1932 the following conditions existed in the United States:
52% of the population received no services from a physician
79% of the population received no services from a dentist
89% received no health examination or similar preventive service
38% received no medical, dental, or eye care of any sort.

The Layman's View About the Costs of Medical Care, p.23. Published by the Julius Rosenwald Fund, March, 1935.

Individual care Illustrated. The figures giving the number of calls per hundred persons shows a striking lack of balance:
Under $1200--1931.9 calls per hundred persons-less than 2 calls per person annually.
$1200-$2000--2045.9 calls per hundred persons--two calls per person annually.
$2000-$3000--2296.7 calls per hundred persons--2½ calls per person annually.
$3000-$5000--2744 calls per thousand persons--2¾ calls per person annually.
$5000-$10,000--3621.4 calls per thousand persons--3½ calls per person annually.
$10,000 & over--4734.4 calls per thousand persons--4¾ calls per person annually.

Debate Handbook, p.66; Article prepared by Dr. Joseph Slavit, Chairman, Medical League for Socialized Medicine.

Incomes since 1929. The decline in income since 1929 affects the amount of medical care the people can provide. Wages have declined since 1929 about 60%. Salaries have fallen 40%. Income from property has dropped about 30%; 300,000 farms have been foreclosed; 20,000 our of 30,000 banks have closed their doors with various losses; ten millions are still unemployed, and 90% of our people are below the $3000 income level.

U. S. Department of Commerce Reports, 1933, on incomes 1928-32.

Uneven Burden of Medical Care. Some families have little sickness during a year, others have a great deal. Therefore some families have small costs to pay for sickness while others have to meet very large bills. If the heavy costs fell only upon well-to-do families, they would not be a great burden. But in fact, heavy charges fall upon families of small means as well as upon those of substantial incomes. The table below shows how unevenly the burdens fall. No family can tell in advance whether it will fall in the lucky group.

10% of the families bear 41% of the costs.
32% of the families bear 41% of the costs.
58% of the families bear only 18% of the costs.

Pamphlet on Costs of Medical Care Julius Rosenwald Fund, Chart No. 8

Medical Charges Incured by Representative Families.
58% have annual charges of less than $60.
32% have charges from $60 to $250.
10% have charges of $250 or more.

I. S. Falk in "The Fundamental Facts on the Costs of Medical Care" reprinted from the quarterly Bulletin of the Milbank Memorial Fund, April, 1933.

Comparison Between Medical and Other Expenditures. In the last prepared summary (1934) the American people spent their annual income in the following manner:

Taxes	9 billion
Food	7 2/3 billion
Rent on Homes	3½ billion
Clothing	3⅓ billion
Amusements and recreation	2 9/10billion
Automobiles	2 9/10billion
Power and light	2 1/8 billion
Home furnishings	1¾ billion
All costs of medical care	1 billion

If we were to exclude from this item those expenditures neither needful nor useful, the total costs of medical care would be exceeded by:

the 900 million we spend on movies
the 900 million we spend on travel and recreation, and
the 700 million we spend on tobacco

It may also be of interest to know that we spend twice as much on candy as we spend on hospitals and twice as much on cosmetics as we spend for nursing.

United States News (Washington, D.C.) July 16, 1934. Reprinted in Discussion Outline on Social Medicine, p.7, prepared by State Medical Society of Wisconsin.

Composition of the Family Medical Bill

Physicians receive	40%
Dentists	18.5%
Hospitals	13%
Nurses on private duty	8%
Secondary practitioners and healing cultists	2%
Medicine	13%
Eye-glasses	2.5%
All other medical services	3%

"The Economic Aspects of Medical Services" p.13, University of Chicago Press, 1935 A summary of Chapters 34 & 35 of Publication No. 27 of the Committee on the Costs of Medical Care.

Distribution of Annual National Bill for Medicines in the United States.

Type of Medicine	DISTRIBUTING AGENTS: Drug Store Pharmacies	Other Retail Agencies	Physicians	Hospitals and Dis-	TOTAL
Physicians prescriptions	140,000,000		25,000,000	25,000,000	190,000,000
Home Remedies	150,000,000	15,000,000			165,000,000
Patent Medicine	335,000,000	25,000,000			360,000,000
Total	625,000,000	40,000,000			715,000,000
Per Cent	87%	6%	25,000,000	25,000,000	

Abstract of Publication No.14,p.4 Committee on the Costs of Medical Care.

"The annual bill for medicines in the United States is $715,000,000. This is nearly as large as the amounts spent annually for physicians or for hospitals. More than 70% of the total expenditure for drugs and medicine is for self-medication, i.e. for patent medicines and home remedies. Physicians are writing fewer prescriptions, and the consumption of ready made, packaged medicines is increasing. In a great majority of the 60,000 drug stores of the United States pharmacists are called upon to devote only about half of their time to the practice of pharmacy."

Abstract of Publication No.14,p.4
Committee on the Costs of Medical Care.

THE PROBLEM AS IT AFFECTS THE DOCTOR

Competition with Private Physicians. By the Veterans Act of 1924, Congress authorized hospitalization of veterans at government expense without regard to the nature or origin of the disability. This extension of government patronage means that physicians and private hospitals must compete with the federal government for the practice of many who are abundantly able to pay for treatment.

Handbook of Sick Insurance, State Medicine, and the Costs of Medical Care. Bureau of Medical Economics, American Medical Association, 1934, p. 134.

President Roosevelt Decreases Aid to Veterans. "Shortly after his inauguration, President Roosevelt, in his effort to balance the budget, convinced Congress that the appropriation for medical care for veterans should be reduced. The appropriation was reduced, and now a veteran is not entitled to free medical service unless his infirmity resulted from illness or injury incurred while serving in the armed forces of the nation.

A survey has shown that about 60% of the veterans being given free medical care were suffering from infirmities of non-service origin. Approximately 40% of the veterans will continue to receive free medical aid from the Federal Government. And if the doctors' prediction comes true, the 60% not entitled to free care from Uncle Sam will procure it from the numerous agencies which make no charge for medical service."

"The Plight of the Doctor" by George W. Aspinwall, American Mercury, p.70,May 1934.

There are 10,000 faith healers, 16,000 chiropractors, 7,700 osteopaths, 2,500 naturopaths, 4,900 chiropodists, 20,200 optometrists, 47,000 midwives, totaling 108,000, as against the 142,000 physicians delivering competing medical services. Likewise 150,000 practical nurses are pitted against 118,000 graduate nurses in private nursing, not to mention the 80,000 student nurses in institutions working with the 95,800 graduate nurses employed there.

Deb ate Handbook on Socialized Medicine
National University Extension Association
September, 1935 p. 78.

Commercial competition against the private practitioner is also very keen, taking the form of hospitals, clinics, medical centers, medical service associations, industrial, mercantile, railroad, insurance, fraternal, and other forms of medical service, and the excessive use of patent medicines and self medication. The extensive and costly advertising campaigns via the press, radio, mails, bill-boards, etc., aids in this commercial struggle.

Inadequacy of Doctor's Incomes. The following table gives the average net incomes of doctors in 1929, our last prosperous year. It will be seen that specialists are the chief recipients of substantial incomes. General practitioners as a class have only modest earnings. Even in 1929 many of them had less than $2000 to live on. Considering particularly their long and expensive education, and the free service they give those unable to pay, most physicians are paid very little.

28,000 specialists.....	$10,000
25,000 partial specialists.....	6,100
142,000 practising physicians.....	5,500
68,000 general practitioners.....	3,900
25,000 general practitioners....Less than	2,000

Pamphlet on the Costs of Medical Care
Julius Rosenwald Fund, Chart No. 11.

It is important to add that, since 1929, the medical and dental professions have suffered an additional 17% decrease in incomes. It is estimated that at present the average net medical income is $3100, the estimated comfort level.

Debate Handbook on Socialized Medicine
National University Extension Association
September, 1935, p. 77

Variation in Income Between Rural and Urban Practice. "The financial returns in rural and urban practice disclose a wide varition. In communities under 5000 the average gross professional income for 1929 was below $5,300. The average net income of physicians in the smallest community group was $3,200 as contrasted with an average of $6,900 in cities of more than 1,000,000. The highest average net income ($7,300) was received by physicians in cities of 100,000 to 500,000."

Abstract of Publication No. 24, p. 5
Committee on the Costs of Medical Care.

Effects of Free Service on Incomes of Medical Men. "Members of the medical profession have always considered it one of their obligations to treat the indigent sick without charge. Persons receiving such treatment have increased to about 1/6 of the population during the past five years. It has been estimated that doctors have been rendering unpaid services in hospitals, clinics, and private practice to the value of $1,000,000 daily, the number of persons receiving free treatment averaging 500,000 daily. It has been pointed out by members of the profession that this burden is one that should fairly rest upon the community instead of the physicians. The Federal Government recognized the justice of this claim when it authorized payments to physicians from federal funds for medical attention to persons on the relief rolls.

Joel I. Seidman-Editorial Research Reports
1934 p. 26

Receiving Free Treatment Becomes a Habit. "Once a free patient always a free patient. Doctors have observed that they rarely ever are visited again by a patient after that patient has acquired the free clinic habit. The patient reasons that he was a fool, indeed, ever to have paid doctor's bills. 'With free treatment just around the corner?' And most of those who first entered free clinics because of the depression never again will patronize their family doctor. They have joined the nation's vast army of free patients, and to what a size that army will grow no one can tell."

"The Plight of the Doctor" by George W. Aspinwall, American Mercury, p.69, May 1934.

Incomes of Specialists Greater than That of General Practitioners. "The average net income of all the 142,000 American physicians was $5500. 25,000 partial specialists showed a net average annual income of $6,100 while the 28,000 full specialists earned a little over $10,000 net average annual income. The 60,000 dentists received an average annual net income of $4800."

Debate Handbook on Socialized Medicine
National University Extension Association
September, 1935, p. 76.

Cost of a Medical Education. Under the present system the cost of a medical education amounts to approximately $10,000.

Section IV, Supplement to the Debate Handbook on Socialized Medicine, National University Extension Association, September 1935, p. 99.

Group Medicine Assures Steady Income for the Doctor. "In the provinces of Saskatchewan and Manitoba, Canada, nearly 50 rural areas assure their doctors a yearly net income of between $3000 and $5000, payments being made through the general tax funds. In Cardston, Alberta, complete medical service, including major operations, is guaranteed to any family for an advance payment of $25 a year. Three fourths of the town's 2000 inhabitants receive the service, and each of the two physicians in the town is assured of an annual income of $3,750."

Joel I. Seidman, Editorial Research Reports 1934, p. 26

What the Wisconsin Medical Profession has Done for the State.

1. State Board of Health brought about by State Medical Society.
2. Laws against quackery and victimization of the sick put into state statutes at the insistence of the organized medical profession.
3. Investigation of medical needs of state carried out by organized medical profession. Upwards of $15,000 expended.
4. State and county provisions for medical service by organized medical profession.
5. Initiating and supporting of quarantine laws, budgets for health activities, institutions for care of insane, tuberculosis, etc., by organized medical profession.
6. Insistence by the medical profession that provision be made from taxes of the community for care of those who are indigent.

7. With same incidence of communicable diseases today that existed in 1910 cost would be added to Wisconsin residents of some 26 millions. Authority-State Board of Health.
8. Hospitals stay reduced from twenty to ten days (1910-35).
9. Increase of numbers of people brought into productive period of life by increase of 15 years in the life-span in state.
   Average age at death in 1908.....40.8
   Average age at death in 1933.....55.4
   Life expectancy of infant in Wisconsin doubled.
   Two generations ago.....30-35 years
   Today.....63 plus years
10. Principle of adapting cost to ability to pay has long been active practice in medical economics--now a pattern for practice in taxation, for instance, state income tax law.

Discussion Outline of Social Medicine, p.16
Prepared by State Medical Society of Wis.

THE PROBLEM AS IT AFFECTS THE COMMUNITY

The problem of medical care not only affects the patient and the doctor, but the community as well. Immunization against communicable diseases, the enforcement of quarantine regulations, proper prôper provision for public sanitation, the dissemination of useful knowledge pertaining to matters of health, public health nursing, and medical relief are but a few of the many phases of this problem which concern the community. It is important, therefore, to know what the government and private agencies have done in order to promote community health.

Hospitals. Hospital beds have increased from 421,000 in 1909 to 890,000 in 1928. There are 7,000 hospitals in the United States and each day, on the average, they care for about 700,000 patients. The following table gives the bed capacity of the various types of hospitals in the United States in 1927:

Nervous and mental	373,564
General	345,364
Tuberculosis	63,170
Isolation	8,895
Convalescent and rest	8,143
Industrial	7,039
Maternity	5,747
Orthopedic	5,595
Children's	5,050
Eye, ear, nose and throat	2,832
Skin and cancer	949
All other hospitals	5,240
Hospital departments of institutions (prisons, orphanages, etc.)	21,930
Total	853,318

Hospital facilities appear to be unevely distributed. Over 40 per cent of the counties in the United States have no hospitals for general community use. All of these counties may not need hospitals, however, on account of sparseness of population, adequate facilities in nearby counties or other considerations. The individual states show a range from 1 bed per 154 persons in Wisconsin to 1 bed per 749 persons in South Carolina. Smaller cities have, in proportion to population, fewer hospital facilities than larger cities.

Of the entire bed capacity of the country, considerably over one-half is provided by the federal, state and local governments; over one-quarter is provided by non-profit organizations for public service, controlled by independent boards of trustees, churches and other bodies. The remaining small proportion of beds are in proprietary hospitals, mostly of small size set up as business enterprises under the ownership of individuals or corporations. By 1927 clinical laboratories had been established by about 4,400 hospitals; X-ray departments were reported by about the same number; physical therapy departments by 2,100.

Clinics and Health Centers. These clinics are maintained by hospitals, governmental and private health organizations, industrial and commercial establishments, schools and colleges, trade unions, courts and prisons, and charitable agencies. Over 2,100 hospitals in 1927 had out-patient departments for the care of ambulatory patients--a function of increasing importance. Among recent developments are "pay clinics" (still very few in number) and "group clinics." In these clinics are gathered together a man with experience in general diagnosis and one or more specialists, with more or less complete equipment for providing scientific medical service, all under single administrative control. Somewhat different from the clinic is the health center. Several hundred centers have been established in recent years, especially since the war. The "health center" usually brings together under a single roof a large number of previously scattered activities for the prevention of disease and the promotion of health.

Governmental Agencies. With the general increase in its activities and powers, the modern state has assumed a more and more important role in maintaining public health. It is noteworthy that, among their other functions, federal, state and local governments controlled hospitals which in 1927 rendered 70 per cent of all hospital service in the United States. These, of course, include large institutions for mental, tuberculosis and other special groups of patients, as well as some general hospitals. There are about 25 agencies in the federal government doing some kind of medical work. The Public Health Service renders important services in the prevention and control of epidemics, conducts research and operates 25 hospitals and 126 out-patient stations for merchant seamen and other beneficiaries. The Children's Bureau collects and disseminates information regarding infant mortality and diseases of children. It has established maternal and infant health centers in cooperation with the states. Among other agencies providing personal medical service is the Veterans' Bureau.

State departments of health engage in the control of communicable diseases, the collection of vital statistics, the control of the water supply and the disposal of sewage, the inspection of food, the maintenance of diagnostic laboratories, and the dissemination of information regarding health and the prevention of disease. The states also maintain hospitals for nervous and mental patients, tuberculosis sanatoria, and institutions for the blind, deaf and mute, feeble-minded and epileptic.

The city or county health department is the primary unit for administering official public health services. Health officers were employed on a whole-time basis, in 1928, by 354 of the 824 cities in the United States with over 10,000 population. Of about 2,500 counties; wholly or in large part rural, 414 at the beginning of 1928 had health departments with one or more health officers on a whole-time basis.

Private Health Organizations. The growing popular interest in public health activities has been stimulated by the establishment of 20 or more voluntary health agencies of national scope and importance and a large number of such local agencies. Some of the fields covered by these associations are tuberculosis, child health, heart disease, social hygiene, mental hygiene, cancer and blindness. In addition to the educational work performed by all of these organizations, some provide certain kinds of medical service.

"Medical Facilities in the United States."
Published by the Committee on the Costs
of Medical Care, October, 1929, pp 8-13
Allen Peebles.

School Health Service. The largest burden of organized school health work is carried on by the city and county public health nurses. Since 1913 Wisconsin has legally provided for the offices of these nurses and has outlined the program of public health nursing and service. Outside of the city of Milwaukee, which alone employs 85 public health nurses, 34 counties in the state employ 39 nurses; 38 cities employ 75 nurses; and 19 boards of education employ 31 nurses.

City Health Nurses. The city nurse is employed by and responsible to the local board of health and health officer. The statutes provide for a broad program in the city nurse's work, including child welfare, school nursing, care of communicable disease, and the care of the sick in their homes when other nurses cannot be provided.

County Nurses. Wisconsin was the first state to make legislative provision for the employment of county nurses (1913). Although the maintenance of these nurses is no longer mandatory, 34 of the 71 counties in the state at the present time employ a county nurse.

Auxiliary Agencies. Out of the 21 counties that answered the query about the outside organizations which aid the nurses and health departments, 20 reported that the Parent-Teacher Associations cooperate in carrying out health programs. One of the important things which the P. T. A. does is to finance various projects such as immunizations, the furnishing of hot lunches and milk, and the fostering of clinics not only for school children but for the pre-school child. The P.T.A. also conducts the summer round-ups and encourages correction of defects found in all children. Here, too, in the counties the activities of the American Legion, Women's Clubs, the Visiting Nurse Associations, and the Wisconsin Anti-Tuberculosis Association are well recognized in the field of child health promotion.

The work done by doctors and dentists who donate their services or charge a small fee for their time is of great significance in the promotion of clinical services throughout numerous counties.

"Guiding Wisconsin's Growing Generations"
January, 1933, pp. 41-49.
Published by the Wisconsin Teachers Assoc.

Extent of Certain Preventive Measures in Wisconsin.

Diphtheria Prevention 1932-1934	Small Pox Vaccination 1932-1934	Tuberculosis Skin Test 1934 only
89,712	104,373	14,343

Those figures do not include the city of Milwaukee.

Compiled by Bureau of Public Health Nursing
Wisconsin State Board of Health

The Wisconsin State Department of Health, organized in 1876, functions under the direction of the State Board of Health and the State Health Officer. Work of the Department falls under twelve classifications, consisting of general administration, vital statistics, communicable diseases and social hygiene, sanitary engineering, plumbing and domestic sanitary engineering laboratories, maternity and child welfare and public health nursing, nursing education, hotels and restaurants, barber shops and beauty parlors, education, and embalming.

Enforcement of the many provisions of the state health code does not mark the limits of service rendered by the Department, for in addition it strives continuously to increase public attention to the benefits of intelligent living gained through improvement of personal and communal hygiene.

Report of the "Activities of the Wisconsin State Board of Health." 1932.

Activities of the State Board of Health. The Wisconsin State Board of Health has been very active in the promotion of community health, and it's record stands as a testimony to it's achievements.

The average age at death in the state in 1910 was 40 years. This has been increased to 53.1 years in 1931.

In 1910 the urban typhoid fever death rate was 44.9 per 100,000 population. This has been reduced to less than one death (0.77) per 100,000 population in 1931.

The infant mortality rate has been reduced to 52.7 deaths per 1000 live births for 1931, a decrease of more than 50% from that of 1908. The maternal martality rate has been reduced to 5.1% in 1929, which gave Wisconsin third honors among the states. In 1931 this was reduced further to 4.3.

"The Board of Health--A Survey", by
Dr. C. A. Harper, State Health Officer.
The Wisconsin State Employees Magazine,
April , 1933.

The Federal Government and Health. One of the methods by which the Government seeks to secure the welfare ot its citizens is through the preservation of their health. The Fathers granted constitutional sanction to these efforts when they laid down the basic function of promoting the "general welfare of the people" in the Constitution. Under that power agencies have been established from time to time for safeguarding the lives and health of the citizens. One of the first such agencies set up was the Marine Hospital Service (1798), which has grown into the present United States Public Health Service. The Service has been, and is, principally concerned with the conservation of the public health and the eradication of diseases affecting man. In addition to the Public Health Service, the Treasury Department

administers two divisions which are only indirectly concerned with public health. They are the Bureau of Internal Revenue and the Customs Service. Of the sixteen bureaus in the Department of Agriculture, eleven are concerned with the health of man. They are: (1) The Bureau of Chemistry, which carries on its work under the Food and Drugs Act, the Tea inspection Act and the Naval Stores Act; (2) The Bureau of Animal Industry; (3) The Bureau of Home Economics; (4) The Bureau of Dairy Industry; (5) The Extension Service; (6) The Bureau of Entomology; (7) The Bureau of Biological Survey; (8) The Bureau of Public Roads; (9) The Bureau of Agricultural Economics; (10) The Bureau of Plant Industry; and (11) The Forest Service. Of the six bureaus in the Department of Labor, four are concerned with public health. They are: (1) The Children's Bureau; (2) The Women's Bureau; (3) The Bureau of Labor Statistics; and (4) The Bureau of Immigration.

Of the twelve divisions of the Department of the Interior, four bureaus are concerned with health and two are hospitals. One establishment which rendered medical service has been transferred to the Veterans' Administration. They are: (1) The Office of Indian Affairs; (2) The Bureau of Education; (3) St. Elizabeths Hospital; (4) Freedmen's Hospital; (5) The Geological Survey; (6) The National Park Service; and (7) The Bureau of Pensions (now in Veterans' Administration).

Of the ten bureaus in the Department of Commerce, six are concerned with health. They are: (1) The Bureau of Census--Vital Statistics; (2) The Bureau of Mines; (3) The Bureau of Fisheries; (4) The Bureau of Standards; (5) The Patent Office; and (6) The Steamboat Inspection Service.

In the Departments of State, Justice and Post-Office are four divisions concerned with health. They are: (1) The Consular Service (State) (2) The Superintendent of Prisons (Justice); (3) The Administration of Postal Laws (post-office); and (4) The Service Relations (Post-Office).

The Medical Department of the Army and the Bureau of Medicine and Surgery of the Navy are the two bureaus which are particularly concerned with the health of the military forces of the United States. Their efforts, however, in some instances touch the general health of the people of the United States.

We find six independent establishments which are concerned with the health of the people. The largest of these is the United States Veterans' Administration, which is charged with the administration of affairs in regard to ex-service men. Then follow the Employes' Compensation Commission, the Board of Vocational Education, the Smithsonian Institution, The Bureau of Safety of the Interstate Commerce Commission, and the Narcotic Control Board.

"The Federal Government and Health"
by Joseph E. Ransdell, Executive Director,
Conference Board, National Institute of
Health. Bulletin of the Pennsylvania State
Department of Health. September-October
1933, pp. 14-15.

Need for Further Application of Scientific Knowledge in Medicine. One phase of the problem of medical care which vitally affects the community is the prevention of unnecessary deaths. There is room for much improvement along this line. "We know how, for example, to get completely rid of typhoid fever, yet, each year, over 4,000 unnecessary deaths are caused by it and ten times that many cases still blot our record. Every shild who dies of diphtheria is, in the present state of our knowledge needlessly sacrificed. But even in 1933, there were at least 4000 such deaths and perhaps as many as 60,000 cases."

The December, 1933 Statistical Bulletin of the Metropolitan Life Insurance Co.

See also page 19 on a continuation of the present system of private practice.

F.E.R.A. Care of the Needy Sick. The inability of many to provide adequate care for themselves during the depression has made this a problem of vital interest to almost every community in this country. In order to aid in providing this care the Federal Emergency Relief Administration issued its "Rules and Regulations No. 7", which laid the foundation for a vast program of medical, dental, and nursing care for families receiving unemployment relief.

The Program announced by the Federal Government enunciated the far-reaching policy that medical care is a necessity, along with the fundamental needs of the relief budget. It declared a second principle of major importance; that the physician should be compensated for his service to the unemployed a nd their families, stated furthermore that the traditional relation between the sick person and a family physician should be maintained wherever possible, and declared that the state and local relief agencies should, in setting up the services, secure advice and systematic cooperation from the organized professional societies. Because of the wide variation among local facilities, local capacities, local standards and local needs, the new regulations permitted a liberal degree of local adaption. Having established certain fundamental principles, certain minimum standards, and outlined an administrative framework, they left each locality free to experiment in the creation of a plan which might meet its peculiar needs. The funds available and the emergency nature of the administration in charge necessarily limited the care that could be provided, and these qualifications underlay the general rules. Service was to be given only to those families which were recipients of unemployment relief and included only those types of care which would be a "Minimum consistent with good professional judgment" to be "charged for at an agreed rate which makes due allowance for the conservation of relief funds."

At the present time all but 19 of the states are providing medical care for the indigent successfully along the line indicated by F.E.R.A. Number 7. Those 19 states may be divided into three classes:

1. States barred by legal or financial limitations.

In 3 of the 4 states which have made little advance, North Dakota, Oklahoma, and Washington, the necessary appropriations have not yet been voted. Fee scales have, however, been approved in North Dakota,

organizations been laid out on paper, and everything is in readiness to begin, once the financial barrier is past. In the fourth state, Delaware, an excellent organization was functioning until April 30, 1930, when the failure of the state legislature to renew the appropriation brought medical relief there to a close. In all of these states some service is being rendered by county physicians, and numerous groups of private practitioners, perhaps inspired by the example of other states, are caring for the indigent under a framework similar to F.E.R.A. No. 7, but without charge.

2. States satisfied with their previously existing program.

Six states,--Connecticut, Maine, Massachusetts, (except for a few cities) Iowa, Vermont, and Nevada,--have been relatively uninterested in the program of F.E.R.A. No. 7 because they possessed an existing system of health care of indigents which appeared to them to be satisfactory.

3. States delayed by administrative-medical professional conflict.

The 9 states which have endeavored to adopt the plan outlined in F.E.R.A. No. 7, but which have been unable to progress far beyond the state of preliminary negotations are Alabama, Arizona, Arkansas, Indiana, Louisiana, Maryland, Nebraska, Oregon, and Virginia. In most of these states previously existing services were at a low level and efforts were made early to secure the benefits of the new set-up. In all of them, however, agreement between the administration and the organized medical profession has been difficult to attain, although some--Maryland, for example, have had brief periods of clam, have been able to pursue work uninterrupted in a few areas, and appear to be on the road toward success at present.

"Medical Care for the Unemployed and Their Families" under the plan of the F.E.R.A. A study by the American Public Welfare Association, pp. 1-7.

The problem of maintaining an adequate standard of health in the community vitally affects every citizen. From childhood to old age the medical care, which a person receives, has important social and economic effects. Does the school in your community properly safeguard the health of it's pupils? Are conditions in restaurants, creameries, and stores sanitary and healthful. Does your own board of health take necessary precautions to provide pure drinking water, to prevent the spread of any communicable diseases, and to provide for proper disposal of wastes? Are the poor in your community suffering because of lack of medical care?

These are but a few of the points to be considered in discussing the problem of health as it affects the community, and the best sources for materials on these points will be found within your own community.

CONTINUE PRESENT SYSTEM OF PRIVATE PRACTICE

Slowness in Advance of Medical Science. "The history of medical and current experience alike serve to illustrate the slowness with which advances in medicine are applied. The story of Scurvy is an illustration. It was known as early as the 16th century that fresh fruit and vegetables would prevent and cure the scurvy common on long sea voyages. In 1754 Dr. James Lind urged that the necessary action be taken to suppress this disease in the Putish Navy, but 41 years elapsed before any preventive action was taken.

For years it has been known that small doses of cod liver oil were curative for Rickets. And yet, rickets is still the indirect cause of heavy child mortality. Much could be done to prevent this if every general practitioner intellized the opportunities he enjoys in his unrivalled access to the homes of the people.

Much could also be done to decrease the death toll due to tuberculosis if members of the profession would use all available facilities for proper diagnosis and treatment.

Section 11, Supplement to Debate Handbook on Socialized Medicine, National University Extension Division, September, 1935, p.38.

The Lack of Organization in the Present Medical Set-up. "Organized medicine has no definite constinctive plan. Its policy is Laissez-faire. It hopes that when and if times improve, the people will be able to purchase medical care; it intends to resort to palliatives to patch up a system which, it admits, has not given adequate care to all the people, nor ampld remuneration to all the doctors, and thus to correct the evils and abuses that are all but annihilating the profession.

It is not made clear just how they can stop advertising and self medication involving the million dollar drug companies, the increased clinic attendance with public opinion to contend with; corporate and lodge practice that has existed for years; cultists of all kinds who thrive in spite of all efforts to eradicate them; fee-splitting and other commercial and degrading practices that are condemned, yet exist now more than ever.

Section 111, Supplement to Debate Handbook on Socialized Medicine, National University Extension Association, September, 1935, p.76 Reprinted from "Medical League for Socialized medicine: Platform or Statement of Principles and Program", pp 1-4. 1934.

Medical Service Personal. Medical service is lacking in all the essentials that would fit it into a system like that used in education and the influences that have been most harmful in education would be more destructive if applied to medical service. There is nothing more individual than medical service. There is no uniformity of methods. The same diseases must be treated differently according to individuals. Every attempt to treat illness in groups and classes has destroyed the value of the service. Standardized methods, whether of appliances and drugs, or text books and lectures such as are used in education do not conform to the accepted practice in most fields of medical care.

An important ingredient in the provision of medical service is the enthusiastic devotion of the physician as expressed in his "will to heal." It is this quality of the physician which has always been the highest characteristic of the profession. It is this quality which entitles the profession to write into its Principles of Ethics the statement that, "When an epidemic prevails, a physician must continue his labors for the alleviation of suffering people, without regard to the risk of his own health or life or to financial returns." The history of the profession, in every nation, is filled with examples of individuals who have suffered disease and death themselves with never a thought of deserting their post of duty.

Idealism is an essential ingredient of medical service. Destroy it and you remove just that vital urge to thought and action that so often divides life and death in fighting disease. This devotion is not a part of the duty of the bureaucrat assigned to a political job. It is destroyed whenever the relations between the physician and the patient cease to be based on personal responsibility and confidence.

Debate Handbook on Socialized Medicine
National University Extension Association
September, 1935, pp 114-116, by R. G. Leland
M.D., Director of the Bureau of Medical
Economics of the American Medical Assoc.

Sick Get Proper Care Under Present System. "No one will deny that there are sick persons who are unable to pay for needed medical service. Facts support the conclusion however, that with all the defeats of the present condition, the low income classes in this country are receiving a better medical service than similar classes anywhere else in the world. The fault of our present system is not with the method of supplying or paying for medical service, but with the method of distributing income."

Debate Handbook on Socialized Medicine
National University Extension Association
September, 1935, pp 126-128, by R. G. Leland
M.D., Director of the Bureau of Medical
Economics of the American Medical Assoc.

Progress in Medical Education Greater in United States than in Foreign Countries. Nowhere else has there been such great progress in raising standards of medical education as in the United States. The opportunity for graduate instruction in the United States is the envy of most all of the other nations. At the time when European nations were introducing systems of sickness insurance, many American physicians found it desirable to visit those countries in order to obtain the highest grade of medical education. The reverse seems to be true now and the opportunities for medical education on this side of the Atlantic are superior to those to be found in Europe. It is quite possible that we are here dealing with cause and effect and that the encroachments of state medicine and compulsory health insurance have so hampered the spirit of progress in medicine as to be, in some degree, responsible for the fact that those nations have advanced less rapidly than the countries without such a hindrance.

Debate Handbook on Socialized Medicine
N. U. E. A. September, 1935, p.126 by
R. G. Leland, M.D., Director of the Bureau
of Medical Economics of the A. M. A.

Present System Places Greatest Burden on Small income Groups. Studies of 12,098 families in 92 cities conducted by the United States Bureau of Labor Statistics showed the following expenditures on sickness during the year 1918-1919 by different income groups.

Income Group	Average Amount Spent in Each Group	Approximate percent of Income Spent
Under $900	$34.10	4.3%
$900 to 1,199	43.34	3.9
$1,200 to 1,499	55.56	4.1
$1,500 to 1,799	67.85	4.2
$1,800 to 2,099	73.75	3.9
$2,100 to 2,499	81.77	3.7
$2,500 and over	95.56	3.7
All Incomes	$60.39	4.0%

Strangely enough, despite the enormous medical charity and the inadequate care wage-earners receive, the costs of medical services, such as they do receive, bear more heavily upon the lower groups than the upper income groups. While the poorest income classes pay the lowest amounts in dollars and cents, their expenditures are the highest in proportion to their incomes.

United States Bureau of Labor Statistics, Cost of Living in the United States Bulletin, No. 357, 1924, p. 453.

Reprinted in Debate Handbook on Socialized Medicine, N. U. E. A., September, 1935, p. 160, by Abraham Epstein, Executive Secretary of the American Association for Social Security. While the figures quoted above are not of a recent date, later surveys indicate that similar conditions exist at present. (See article quoted above).

Must Have Private Practice to Retain Initiative. "Already our people have been spoon-fed by the hand of the government until they have left much of their independence. A long step toward the complete loss of self-respect and man-hood would be taken if they were still further pauperized by having free medical service forced upon them. It is almost impossible to overestimate the effect state medicine would have on the doctor, who is an individualist by nature and by training. He learns to rely on himself and is cramped if forced to take orders from higher authority. However, under the competition in private practice the members of the medical profession have brought forth their greatest efforts. Under state medicine, inevitably the old relation between doctor and patient would be destroyed. There could not be the same interest taken in his patients by a doctor working for the state as by one in private practice. In no other profession does the personal equation count for more than in medicine; and nothing would destroy this more quickly than state medicine; particularly if practiced by groups."

Wingate M. Johnson, M.D., Winston Salem, North Carolina, Congressional Digest, August September, 1935, p. 213.

Minority Report of Committee on Costs of Medical Care Favor Private Practice. "The minority report recommends that united attempts be made to restore the general practitioner to the central place in medical practice. It opposes all forms of medical practice which make it difficult to maintain the personal relationship of physician and patient. It disagrees with the majority report that savings in the cost of medical care are to be made by eliminating the general practitioner or submerging him in a group. The great majority of illnesses and injuries (about 85%) are of such nature that they can be treated efficiently by any able practitioner with very simple equipment."

Extracts from Minority Report of the Committee on the Costs of Medical Care, Reprinted in Congressional Digest, August, September, 1935, p. 215.

System of Private Practice Too Costly. Reflect on the extravagance of the present incoherent, multifarious health agencies in our commonwealth. Second, the federal health services, phblic health, child welfare and maternity, and also various private national societies and institutes of hygiene and medicine with state branches. Third, the local boards of health with their hospitals for contagious diseases, and the school health department, police and private ambulance services, diverse hospitals, municipal as well as private, charitable and industrial, general and special, different health centers, district nursing societies, Red Cross workers, private physicians, and nurses, pharmacists, masseurs, cultists of nearly the fifty-seven proverbial varieties, mediums, quacks, abortionists, herbalists, fakers, and dispensers of "patent" medicines.

"In Defense of State Medicine" New England Journal of Medicine, p.1678, May 29, 1930 by G. W. Haigh. Reprinted in the Handbook of Sickness Insurance, State Medicine, and Costs of Medical Care published by the American Medical Association, p. 126, 1934.

PROMOTE VOLUNTARY GROUP MEDICINE OR INSURANCE

Types of Group Medical Service. There are various methods of providing medical care other than through a continuation of the present system of private practice.

1. Group Medicine proposes that groups of medical men co-operate to give medical services to people of moderate means on an easy payment contractual basis. (This plan has been recommended by the Committee on Costs of Medical Care. Some 350 of these plans are in existence at the present time.)

2. Health Insurance is an extension of the insurance principle to medicine. It has various forms, some of which are the workman's compensation service, industrial insurance, and health and accident insurance. The greatest objection to health insurance is that it is generally organized on a profit basis. Health insurance may be either voluntary or compulsory.

Historical Aspects of Medical Care. The importance of medicine for the community has long been recognized by society. Although the Greek world 500 B.C., knew comparatively little about medicine, Plato advocated a form of community medicine. Among the early Greeks, medicine was commonly practiced by wandering doctors who went from place to place knocking on doors, peddling their services. In some cases in the larger communities a permanent physician was retained by a small public tax. His income was augmented by gifts which he was permitted to accept from the more wealthy patients. The Greeks perhaps gave us an example of the first attempt at organized medicine.

Several centuries later Christianity introduced the attitude that the sick and afflicted should be viewed with a spirit of charity. This attitude had its influence in medieval times among the guilds. The wealthier guilds owned and operated a form of hospital service for their own members and organized mutual sick benefit societies with special funds which were used only for emergencies such as severe illness and death.

During the last century and a jalf the principle of health insurance spread rapidly through most of Europe but the movement had its strongest following in Germany. It took such a wide-spread calamity as the cholera plague of 1931 to arouse the masses to the appalling conditions of health. Under the Public Health Act in 1848 Germany became a leader in sanitary improvement and in founding medical societies that became patterns of socialized medicine in many communities. By 1900 nearly all European countries had established some kind of social insurance and it is significant to note that there is practically no important opposition to the principle of health insurance in any country where it now exists.

In the United States, since the Civil War, various forms of group medicine, private clinics, pay clinics, free clinics and sickness insurance have been formed. In 1930 through the Workmen's Compensation Laws and voluntary action by many corporations medical care had been made available to more than a million men on a small fee basis. Many communities have through voluntary associations and hospitals made much progress in distributing the burden of medical costs among the people. We can see the evidence of an unmistakable trend towards various types of experimentation in medical economics.

Debate Handbook on Socialized Medicine
Northern University Extension Association,
September, 1935, p. 21-22.

Examples of Group Medicine Colleges. In more than 150 colleges and universities there are student health services, some of which have been functioning for fifty years or more. Some of these furnish complete medical services. Well over a million students and teachers are included in such groups, a good share of the grand total. At the University of California complete care--physicians' services, dental work, hospitalization, physical-therapy, x-ray and drugs--is furnished to ten thousand students at a cost, including capital charges, that averages $18 per year per eligible student. At the University of Michigan the needs of more than 12,000 students are looked after at a total cost to each student of $10 dollars a year. The University of Wisconsin also has a system of student health which serves its students at a nominal cost.

Rural Communities. A number of rural communities, faced with the plain fact that if they wanted medical care they would have to assure a competent man a fair income or go without it, have organized themselves as consumer groups. By guaranteeing a doctor a good salary a district is assured adequate care. The rural group plan is often somewhat disguised by the fact that a competent man will remain in a locality because he is paid by the local government for treating the indigent or for public health work. But he is a group physician in fact if not in name.

In Saskatchewan and Manitoba, Canada, nearly fifty rural areas have group plans in which physicians are paid through general taxation. These physicians are usually health officers as well, and the system has been operating successfully since 1921. The doctors are assured from $3,000 to $5,000 net income each year, and both patients and doctors appear well satisfied with their bargain. Freed from the necessities of bill collecting, the doctors report that they are able to do better work. Unfortunately most rural areas are without adequate hospitals and such costs come extra. The present service, if paid for direct instead of through taxation, would cost each family from $7.50 to $10 per year. Of such plans H. L. Mencken once wrote: "A few unusually enlightened rural communities have induced doctors to settle in them by offering guaranteed incomes to competent men, but it must be plain that such communities are too intelligent to be numerous.

The Laymans View About the Costs of Medical Care, p. 8-10, March, 1935. Reprinted from "Cutting the Cost of Sickness" by J. H. Chamberlin, World's Work, June, 1934.

Cities. Group medicine is continually growing in this country. A few of the cities in which various forms of group medical service are operating are:

Los Angeles, California-Ross-Loos Medical Group; Organized April 1929; serving 40,243 persons.
Sacramento, California--Superior California Hospital Association; Organized June, 1932; serving 5956 persons.
New Orleans, Louisiana--Hospital Service Association of New Orleans. Organized April, 1934; serving 35,000 persons.
St. Paul, Minnesota--Hospital Service Association. Organized April 1934, serving 8380 persons.
Newark, New Jersey-Associated Hospitals of Essex County, New Jersey. Organized January 1933; serving 6,000 persons.
Durham, North Carolina--Hospital Care Association, Inc. Organized November, 1933, serving 4,989 persons.
Cleveland, Ohio--Cleveland Hospital Service Association. Organized July, 1934, serving 11,000 subscribers and dependents.
Houston, Texas--Hospital Service Association, Inc. Organized January 1933; serving 5,897 persons.
New York City--Associated Hospitals, Inc. Organized May, 1935; serving 7000 subscribers.

Section VII, Supplement to Debate Handbook on Socialized Medicine. N.U.E.A., September 1935, by C. Fufus Rorem. Ph.D. P.200-207.

Elk City, Oklahoma--Community Hospital; organized 1929, serving 1800 families.

Layman's View About the Costs of Medical Care, p. 30. Julius Rosenwald Fund, March, 1935.

Group Hospitalization. Another development of late years has been the establishment of "group payment" plans by hospitals and other agencies. Through the payment of a flat sum each month, the patient is assured complete hospitalization, and in some instances the services of a physician when he becomes ill. This charge may vary from fifty cents to two dollars depending upon the type of care rendered.

About thirty cities have group payment plans in operation and about fifty more are in the process of formation. For a small sum the patient is guaranteed hospital care which might cost him $300. The idea is growing rapidly, and several state medical societies have approved group pay plans. They have the active support of the American Hospital Association and the Western Hospital Association. One thing is certain: the hospitals have been helped to weather troublesome economic seas, and so have the patients.

The Layman's View About the Costs of Medical Care, p. 8-10, March 1935. Reprinted from "Cutting the Cost of Sickness" by Jo H. Chamberlin, World's Work, June, 1934.

Industrial Medicine. Group medical care under industrial supervision has been carried on to a great extent in this country. The plans in operation in the Homestake Mining Company of South Dakota, the Endicott-Johnson Company of New York, and the Goodyear Tire and Rubber Company of Ohio, are but a few of the numerous instances in which industrial workers have been benefited by this form of medical service.

Insurance Medicine. Insurance medicine has also found some favor in this country, but is opposed by many, because:

1. Profit to insurance companies is an essential factor.
2. Politics will surely enter. Insurance companies maintain expensive lobbies.
3. Insurance companies will control the medical policies.
4. Competition by doctors for jobs with insurance companies will be a certainty.
5. The doctor will be insecure in his position and earnings.
6. Medical insurance is not applicable to all patients, but only to those who are able to pay for the costs of insurance.
7. Experience with the present compensation law yields poor results to both patient and doctor.

Section 111 Supplement to Debate Handbook on Socialized Medicine, N. U. E. A., September, 1935, p. 73-74. By the Medical League for Socialized Medicine.

ADOPT A SYSTEM OF STATE MEDICINE

Socialized Medicine implies a system of free medical care and practice sponsored and financed by the state, responsible to the state, and organized, operated and regulated democratically by the medical and allied professions.

State Medicine implies the very same thing as above, except that the system of medical care and practice would be organized, controlled and regulated BY the state FOR the medical and allied professions.

The essential difference between socialized and state medicine is that under the former the control is vested in the medical profession and under state medicine the control is vested in the state. We have many other forms of socialized service similar to state medicine. A few of them are our police system, libraries, educational system, parks, etc.

Sickness Insurance and State Medicine in Other Countries. State provisions for sickness insurance are found in 36 countries. In 21 countries, including most of the leading industrial nations, the plan is compulsory for certain groups in the population. In 12 countries sickness insurance is voluntary, and in 3 both types exist, with different classes of people covered by each. In some of the countries with voluntary insurance, medical care and indemnification for loss of earnings due to sickness are provided by government-subsidized mutual benefit associations.

The cost of sickness insurance is customarily met by periodic contributions from employers and employees, with the state in some instances contributing directly or assuming some of the administrative expense. The chief emphasis has usually been upon the payment of cash benefits to compensate for the loss of earnings during illness. This contrasts with most American proposals, which provide only for hospitalization and medical care. In most countries the cash benefit paid ranges from half to two-thirds of the wages usually earned. Benefits are usually limited to 26 weeks. Benefits for dependents are absent from some of the plans, permissive in others, and compulsory in five or six of the newer systems.

The Danish voluntary system covers a larger proportion of the populace than any other plan, compulsory or voluntary, with 45 per cent of the people belonging to recognized funds in 1930. Belgium had the next most extensive coverage among voluntary plans, with about 15 per cent. Among compulsory plans, Great Britain and Germany have the highest coverage, with 36 and 32 per cent, respectively. If dependents were included, however, the German percentage would be about 58. In some countries, including Finland, Italy, and Spain, the proportion of the population insured is as low as 2 per cent.

The English plan dates from 1911, with health insurance now compulsory for all persons of moderate incomes. Fixed cash payments are made without regard to former earnings, the rate being reduced after 26 weeks of continued sickness. Medical attention from a general practitioner , together with necessary drugs, is provided in the plan, but hospitalization is not regularly available. Approved voluntary sickness organizations, now numbering about 1,000, are included in the plan, and entrusted with the administration of benefits. Persons of low income in many instances obtain hospitalization through semi-charitable "contributory schemes," in which

the contributors pay low annual amounts intended to provide only part of the necessary costs. The British Medical Association which strongly opposed the health insurance law when it was passed, now endorses it.

Germany has the oldest existing governmental plan, established by Bismarck in 1883. Originally limited to industrial workers, it has been extended to include commercial workers, domestic servants, and agricultural laborers. In addition to cash payments and medical care, maternity and funeral benefits are paid.

Russia has a system of state medicine, with all health institutions controlled by the state. Medical service is furnished by the local branches of the Commissariat of Public Health, the full cost of all insurance for wage-earners being paid by the state as employer. Frequent examinations are made, and a patient is treated as a member of the community whose efficiency must be increased if possible.

Under the Soviet regime there has been an enormous increase in the number of physicians. The physician has been removed from the field of monetary competition, and private practice at the present time probably constitutes less than ten per cent of medical treatment.

Joel I. Seidman, Editorial Research Reports
Volume 11, 1934, pp. 36-37.

Partial State Medicine Now Exists. In our so-called capitalistic state we do have a partial system of state medicine. "In 1931, sixty-six percent (66%) of all the hospital beds in the United States are under government control. More than one-half of the general hospital care is provided by cities and counties through local hospitals." (Wilbur Report). More than 50% of all ward cases in our voluntary hospitals in Greater New York are now subsidized by the government. Approximately 40% of all ambulatory cases are handled through the city hospitals.

Section III, Supplement to Debate Handbook on Socialized Medicine, N. U. E. A., September, 1935, p. 75 by the Medical League for Socialized Medicine.

It may also be noted that state medicine would merely be an extension of the principle now operating so effectively in our Army and Navy Medical Corps. The excellent manner in which these medical corps stood the strain to which they were subjected during the World War would indicate that a similar system might operate effectively now.

Program of the Medical League for Socialized Medicine. The Medical League for Socialized Medicine submits the following platform or program of measures and means to be developed into law, and to serve as a basis upon which to establish an adequate system of Socialized Medicine, with adequate care of the people by the doctors and adequate care of the doctors by the people:

1. Adequate medical care of the sick and injured as a socialfunction, right and duty, and not as a private or public charity. Curative as well as preventive means, measures, and agencies to be included.
2. A socialized system of medical care in health, illness and injury free of fees.
   (a) Under the auspices and with the sibsidy of the state.
   (b) Financed by taxation, similar to the public educational system or other governmental functions.

(c) Operated and regulated by the organized medical and allied professions, the medical and dental colleges and the officials of existing public health agencies.
(d) This system to include all dental, pharmaceutical, nursing and allied services and personnel.

3. All hospitals, clinics, laboratories, pharmacies, etc., to be publicly owned and operated institutions, accessible to the sick free of charge. The hospitals and clinics to be the medical centers for ward and ambulatory cases, and to be properly organized, coordinated and geographically distributed. House sick calls to be received at these centers and to be assigned to local or neighborhood physicians designated to cover specific local territories.
4. All equipment, supplies, laboratory and other facilities of a medical, surgical, dental, pharmaceutical, nursing or other nature, to be furnished free by the state.
5. All medical dental, pharmaceutical, nursing and allied education to be furnished free by the state.
6. All duly licensed or registered physicians, dentists, druggists, nurses, etc., to be legally entitled to practice under the system as full time practitioners or workers.
   (a) Subject to established rules and regulations of admission and practice.
   (b) Proper safeguards of their rights and privileges under the system and the law.
   (c) With representation and a voice in the operation of the system.
7. Compensation to be adequate and on a salaried basis.
   (a) Graded according to time of graduation, length of service in the system, rank held, and type of work.
   (b) Salary increases and promotion to higher ranks to be based on similar considerations and to be automatically enforced.
   (c) Pensions, sickness, old age and other disability and social insurance to be included and applied.
8. Hours of work to be assigned and regulated and scheduled as to provide:
   (a) Adequate medical care for the sick and injured at all times.
   (b) Adequate time and opportunity for the physicians and allied workers for rest, recreation, vacations, and further professional study--with pay.
9. Organized cooperative groups and group methods to be employed under the system wherever possible. Special provisions to be made for rural and other territories inaccessible to regularly organized medical centers.
10. Individual private medical practice permissible under the same conditions and regulations as in private education, plus existing licenses and requirements by the state.

How State Medicine Would Benefit the Nation.

Under Present Methods	Under "State Medicine."
1. There are in the United states about 150,000 real physicians, besides many other so-called "doctors" who greatly hinder medicine from doing its best and its honorable exponents from receiving for their service a proper pecuniary reward.	1. There will be only as many physicians nurses, druggists, masseurs, etc., as needed to do the work well. There will be no "schools" of medicine, cults or 'isms. As honest medical service will be free, quacks will find their occupation gone.
2. In many towns there are many more doctors than are needed, while in many rural communities there is no resident medical service whatever.	2. Like the postal service, the health service will reach every family in the nation. Every community will be a part of some health district, served by all that medical science has to offer.
3. Medicine makes progress, but only in spite of great obstacles.	3. Medicine will make greater and more rapid progress when collectively organized; organization will eliminate obstacles.
4. Research work is now done largely by business enterprises and in endowed institutions. Commercial profit has caused many questionable innovations to be foisted upon the profession.	4. Research work will be a part of the National Health Service. Its only motive will be to discover new truths and to enhance the success of the department; there will be no money profit. The Bureau of Standards at Washington is an illustration.
5. All kinds of false theories are promulgated for money gain. The profession and the public are constantly exploited in this way.	5. All new ideas will be tested and if found of value will be added to medical science. The inventor will be rewarded, of course; but there will be no swollen fortunes reaped by either true or false innovations.
6. Doctors in general are poorly paid. Their incomes are from fees irregularly collected, and the financial side of their work is constantly interfering with the professional side. Most of them are greatly worried as to the future of themselves and families in case of such ill-health as would necessitate giving up their profession.	6. Doctors will be paid liberal salaries-they will do their very best to hold their places and to secure advancement in the service. The economic side of their work will have no bearing whatever. In ill-health they will be sure of a pension, and will thus be relieved of that source of anxiety.
7. Few people live properly.	7. People will be taught to care for their bodies, thru a real health service.
8. "People are not anxious to consult their family physician, except in the presence of a tangible condition, such as pain or incapacity of some kind."	8. Periodic health surveys will enable physicians to practice preventive medicine, and as consultations will be free and with the full confidence of the patient in the integrity of the examiner, advice will be sought early and usually long before there is any marked incapacity.
9. Consultations with specialists are so expensive, and so frequently result in the referring practitioner	9. Consultations being free, there will be no loss of prestige of the physician, and suspected cases of

losing the patient, that consultations are usually too long deferred.

10. The medical profession thinks the rich and well-to-do should pay for services rendered the poor; but people of means resent being penalized in this way, and no other vocation does it.
11. Millions are spent yearly for self- and counter-prescribed medicines. The physician is called as a last resort.
12. Doctors are competitors of each other. While they are supposed to be guided by a code of ethics, economic pressure often makes this code impossible and many resort to all the chicanery of petty "business."

13. A doctor, who has once been licensed, cannot in Ohio at least, be deprived of the right to practice medicine by being convicted of a penitentiary offense. No matter how negligent he may be, how reckless he may become, how utterly behind the times in matters of medical progress, he may continue to practice medicine with impunity.

14. Hospitals are largely centers for group or staff activities, and the publicity connected with them is a great professional asset. Their rules of conduct serve largely to eliminate competition.
15. Very few physicians keep any histories of their patients aside from the entry of charges for professional services.

16. The public is kept grossly ignorant of the utter insignificance of the vast majority of the little disturbances which leads patients to consult physicians. Physicians usually give a prescription or hand out a little medicine, without explanation, and the recovery of the patient within a few hours or days is naturally attributed by him to the

cancer, appendicitis, ectopic pregnancy, etc., will be promptly referred to specialists and innumerable lives will be saved by prompt intervention.
10. Unto every man according to his need, will be the motto of medicine. The best we know to all alike, rich and poor.

11. There will be no drug traffic, no patent medicines, no nostrums. Preventive medicine will eliminate very largely the use of drugs.
12. There will be complete professional cooperation and health activities will predominate. The only competition will be as to who can render the best service or bring about most progress. Such a service would bring out the best qualities of each individual.
13. His work being under supervision, the Board of Examiners will unquestionably be empowered, in case his gross incompetency becomes evident, to retire him from the practice of medicine in order to conserve, in the only possible way, the paramount interests of the public. In other words, he will not only know enough to pass examinations when he enters the profession, but he must, thereafter, maintain his standing or drop out.
14. Hospitals will be a part of the health service; they will not be used selfishly, because medicine will not be a business and there will be no competition in the ordinary sense of the word.
15. Physicians will be required to keep notes of condition of patients and their progress, and will have time for such notes as they will not need to make charges or look after collection.
16. The public will be informed of the evanescent character of these troubles and drugs will be given only as needed or as desired for alleviation of symptoms. Every effort will be made to instruct the public as to the fact that less than one-tenth of their ailments are really of serious import, but that one-tenth needs the very best that medical art and science can afford. (The in-

medicine which he took; and thus again and again he returns under similar circumstances and gets similar treatment. (The interests of patient and physician are antagonistic.)

terests of patient and physicians are identical.)

"Should Medicine Be Socialized?" by Dr. E. L Hergert, Brooklyn, N. Y. Medical Journal & Record, April and May, 1932. Reprinted in "Socialization of Medicine." August 1935, pp. 240-245. H. W. Wilson, Co.

Arguments Against State Medicine.

1. It would create a dole in medicine.
2. The doctor would lose his independence.
3. The ambition and initiative of the doctor would be lessened.
4. The patient would lose his right of free choice of doctor.
5. Political evils would result.
6. The cost would be excessive.
7. Patients would be handled in mass.
8. An obnoxious government bureaucracy would result.
9. The medical profession is at present adequately handling the medical problem.
10. Other methods offer a better solution to the problem.

Arguments For State Medicine.

1. State medicine would eliminate much of the overlapping of medical service now existing.
2. The cost of medical education would be decreased.
3. Adequate salaries would be provided for all doctors.
4. There would be a better distribution of medical facilities and services.
5. State medicine has succeeded in foreign countries.
6. State medicine is already in existence in this country.
7. Work in preventive medicine would be extended.
8. The money now wasted on patent medicines would be saved.
9. Make the latest scientific equipment available to all doctors.
10. Provide a more equitable distribution of the costs of medical care.

FURTHER READINGS

Besides the information that can be acquired by making a study of local conditions and that found in this mimeograph, the Department of Debating and Public Discussion, University Extension Division, Madison, has prepared material that can be secured for loan purposes on request to that department. Any of the material listed below may be secured there. In requesting loan package libraries from the Department of Debating and Public Discussion, it is desirable to give the date upon which the information can be used to advantage, in order that the latest material may be at your disposal. Also, the particular articles desired should be specified; otherwise a more general package of material will be sent.

General

1. Survey Graphic, December, 1934. (Special issue on medical care).
2. "A Picture-Book about the Costs of Medical Care", Julius Rosenwald Fund, 4901 Ellis Avenue, Chicago, Illinois.
3. Debate Handbook on Socialized Medicine. Prepared by the National University Extension Association, September 1, 1935.
4. "Medical Economics" by Brooks Quimby. (Includes a bibliography and discussion).

TOPIC 1. The Problem as it Affects the Patient

5. "The Economic Aspects of Medical Services". Reprint of two chapters of Publication No. 27 of the Committee on the Costs of Medical Care (January, 1933). The University of Chicago Press, Chicago, Ill. 1935.
6. Fundamental Facts on the Costs of Medical Care. by I. S. Falk. Reprinted from the Quarterly Bulletin of the Milbank Memorial Fund Volume XI, No. 2, April, 1933.
7. The Ability to Pay for Medical Care. Publication No. 25 of the Committee on the Costs of Medical Care by the University of Chicago Press Published by Louis S. Reed, Ph. D.

TOPIC 2. The Problem as it Affects the Doctor

8. The Costs of Medical Education by R. G. Leland, M.D., Assistant Director, Bureau of Health and Public Instruction. American Medical Association. Chicago. Reprinted from The Journal of the American Medical Association, Feb. 28, 1931, Vol. 96, pp. 682-690
9. Incomes of Physicians. Abstract of Publication No. 24 of the Committee on the Costs of Medical Care, by Maurice Leven, Ph.D., December, 1932.
10. The Plight of the Doctor by George W. Aspinwall. The American Mercury May, 1935.

TOPIC 3. The Problem as it Affects the Community

11. The Public Health Nursing Program in Wisconsin. Mimeograph issued by Department Debate and Public Discussion, University Extension Division, University of Wisconsin.
12. Municipal Doctor (See No. 20).
13. State Board of Health. Thirty-fifth Report by C. A. Harper, M.D. State Health Officer, Madison, Wisconsin, 1934.
14. White House Conference-Child Health and Protection, November 19-22, 1930 Section 11. Public Health Service and Administration distributed by American Child Health Association, 450 Seventh Avenue New York.

TOPIC 4. Continue Present System of Private Practice

15. Health Services of Tomorrow by Thomas Parran, Jr., M.D. Commissioner of Health of the State of New York, Albany, N. Y. printed in The Medical Profession and the Public published by The American Academy of Political and Social Science, Philadelphia, 1934.
16. Discussion Outline Social Medicine and Sickness Insurance by J. G. Crownhart, Secretary, State Medical Society of Wisconsin

TOPIC 5. Promote Voluntary Group Medicine and Insurance

17. Editorial Research Reports on Sickness Insurance and Group Hospitalization by Joel I. Seidman. Volume 11, 1934, Number 2, Editorial Research Reports, 1013 Thirteenth Street, N. W., Washington.
18. Private Group Clinics-Abstract of Publication No. 8 of the Committee on the Costs of Medical Care, January, 1931.
19. Section VI-Alternative Plans for Medical Care, supplement to Debate Handbook on Socialized Medicine, National University Extension Association, September, 1935.
20. The "Municipal Doctor" System in Rural Saskatchewan-Abstract of Publication No. 11 of the Committee on the Costs of Medical Care by C. Rufus Rorem, Ph.D., C.P.A.

TOPIC 6. Adopt a System of State Medicine

21. Section III Arguments for Socialized Medicine, supplement to Debate Handbook on Socialized Medicine, National University Extension Association , September, 1935.
22. Section IV Arguments Against Socialized Medicine, supplement to Debate Handbook on Socialized Medicine, National University Extension Association, September, 1935.
23. Congressional Digest, August-September, 1935 article by William D. Chapman, M.D., Silvis, Illinois.

Additional suggestions for further study are to be found on p.8 of the Debate Handbook on Socialized Medicine which will be furnished with all loan packages. A special bibleography is included on pp. 201-220 of this same handbook. Your family doctor and county or school nurse can give you much information on the problem in your own community. You should avail yourself of this additional source.

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