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R. W. TUCKER

the case for socialized medicine

A SPECIAL REPORT

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This issue consists of a special report designed to bring you fully up to date on all aspects of the fight for reform of medical services in America. It reflects the recent renewal of public interest in the government's role in medicine as expressed in such legislative proposals as the Forand bill. The author, R. W. Tucker, is chairman of the Committee on Medical Economics of the Socialist Party-Social Democratic Federation.

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The Case for Socialized Medicine

by R. W. Tucker

1: CRISIS IN MEDICAL COSTS

THE MOST urgent argument for socialized medicine lies in the fact that medical costs are caught in an inexorable price squeeze.

The problem of paying for medical care is itself as old as mankind. Among our remote ancestors undoubtedly were some who had to remove to less comfortable caves so they could afford a witch doctor. Two thousand years ago, the New Testament records that Jesus healed a woman who for twelve years "had spent all her living upon physicians." (Luke 4:42)

But today's medical technology gives a new importance to the problem of medical costs. And at the very same time, medical costs are rising relative to other costs, so that the problem is getting worse quantitatively as well as qualitatively.

In view of the general inflation we can best understand the dimensions of this mounting crisis, by translating rising medical costs from dollars and cents into the number of hours of work it takes to pay for a given amount of medical care. In 1936, with one week's wages a typical electrician could buy almost *thirteen* days of hospital care. This was in the depth of the depression. By 1956 with one week's wages an electrician could pay for only *nine* days in the hospital. This was before the first big post-Korea recession, and after twenty years of steadily higher wages.

Likewise, in 1936 a stenographer could buy eight hospital days with a week's wages; by 1956 she could buy only five-and-a-half.[1]

The rise in medical costs cannot be reversed because it stems from condi-

tions beyond anybody's control. It's due, first, to progress in medical technology, which especially in hospitals means new and expensive equipment, and many more people on the payroll. In 1946 there was a nationwide average of three hours worked by hospital employees for every two patient bedhours. Only nine years later, in 1955, the average had gone up to four hospital employee-hours for every two patient bedhours—an increase of one-third in just nine years.[2]

The second basic reason for rising medical costs is summed up in the economic principle that as an economy industrializes, the relative cost of goods goes down and the relative cost of services goes up. In other words, rising medical costs are an expression of automation. As automation becomes more general, industries that cannot adapt to it become more expensive. Handcrafted goods cost more than factory-made goods; servants are replaced by household appliances; food is first canned, then frozen, and finally we get TV dinners. And medicine, which continues to require the services of people, costs more and more and yet still more.

A major depression may possibly slow down the rise in medical costs. Nothing will halt it.

Who Shall Subsidize?

People must have medical care, and its cost will continue to rise. The question is not whether medical care should be subsidized; the question is who shall subsidize it.

Today our hospital costs are subsidized by the misery of hospital workers. They're one of the most cruelly exploited groups of workers in America; their plight is matched probably only by that of the migratory farm workers. Under the laws of most states they don't even have union rights, and if they go on strike they can all be fired with impunity.

The 1959 hospital strikes in New York City and Chicago revealed to a shocked public that a large proportion of fulltime hospital workers received so little money, that while working they also qualified for public relief.

New York City's Central Labor Council, taking on this occasion its first good hard look at hospital conditions, declared that "we have sweatshop health standards in our hospitals. They underpay their staffs and underserve their patients. They make no accounting to the public." It went on to announce its intention of building its own chain of hospitals. (To which one hospital official rejoined, "Welcome to the deficit club!" No answer, of course, to the questions of service and accountability; but perfectly correct in suggesting that unions, just like everyone else, will have a very hard time offering better services cheaper, and still paying adequate wages. The problem is *not* merely one of eliminating inefficiency and profiteering.)[4]

According to testimony before the House Ways and Means Committee, in 1946 hospital employees below the rank of nurse or technician were getting nationwide average wages of only $1,330 a year for a 48-hour week. By 1957 they were getting double that, an average of $2,873 for a 42-hour week[5]; this raise was a major cause of rising medical costs during that period. Yet this is still an average of only $55 and change for a week's work (that's a living wage?). This is the kind of money we pay people *in whose hands our lives may lie.*

AUTOMATION HITS THE HOSPITALS

What happens when hospitals try to economize through automation?

An answer is found in the sad story of the "autoanalyzer." This device performs automatically the four or five basic tests which, back in the Twenties, made up most of the work performed in hospital laboratories. It tests for calcium in six minutes; by hand this test can take up to twenty-four hours. Undoubtedly the autoanalyzer saves time, increases productivity, and reduces the bills hospital patients have to pay.

There's just one thing wrong: Since the Twenties some 250 new laboratory tests have been developed and standardized. These tests still have to be done by hand.

Mathematically, if the present ratio continues (there's no reason to suppose it won't) by the time machines have been invented for all 250 tests, there'll presumably be some 11,000 more new tests to be done by hand.[3]

Where the Money Comes From

When you consider how fast medical costs are going up, and consider further that the rise is inexorable, you presently start to wonder how long we can afford to let this process go on. In fact, we are fast approaching a situation where only the Federal government will have the resources needed to foot the nation's medical bill.

For consider where the money comes from now, such of it as there is, to pay for our present inadequate system:

Philanthropy—traditionally a major source of money for the medical industry—is a source that's rapidly drying up. Hospital fund drives, the March of Dimes, and all similar projects put together now add up to only about 5 per cent of the nation's medical bill, and this percentage is going down.[6]

Drug companies and colleges between them used to pay for most medical research. Increasingly the government is taking over this end of medicine. Not, to be sure, very adequately: In 1959 we spent $400 million on medical research, and we spent $550 million on get-well cards, florists' bouquets, and other convalescent greetings.[7] (So much for social priorities.) Recent Congressional investigations, with their revelations of 7,000 per cent markups on drug prices, have made it plain that the drug companies' involvement in this field is far from disinterested. The revolution in medical technology clearly is not the result of consistent national effort, but is taking place *in spite* of the lack of such effort. How much further might we not already have gone with more money and more push?

Insurance is of course caught in the same price squeeze that affects all other medical costs. When hospital expenses go up, sooner or later so do premiums. This applies equally to the cooperative and labor-sponsored programs, the nonprofit "Blue" plans, and of course to the commercial companies. All insurance comes ultimately from patients, and perhaps shouldn't be considered as a separate category from out-of-pocket payments by sick people. But at any rate, it covers only one-quarter of the total health bill[8]—and only one-third the bill of people who are insured.[9]

Robin Hood once paid a large share of medical costs. That is, doctors traditionally overcharged the rich and undercharged the poor. But this is going out of fashion. For one thing, bills are now so high to start with that the rich won't sit still for it any longer. For another thing, despite AMA heeldragging, health insurance is gradually bringing about fee standardization. Most doctors do free work among the poor, which of course is laudable and, I sincerely believe, good for their souls; but this hardly solves a national dilemma.

Most of the money to pay medical bills comes out of patients' pockets. About 67 per cent,[11] to be exact. And each year sees a steady erosion of private fee-paying patients, as people in higher and higher income brackets are forced to turn to hospital outpatient departments and clinics for the poor.

2: FAILURE OF THE BLUE PLANS

WHEN TRUMAN tried to get socialized medicine enacted into law, back in the late Forties, the chief instrument of his defeat was Blue Cross and Blue Shield. These are nonprofit medical insurance plans, run respectively by hospitals and by doctors, with premiums supposedly adjusted to members' incomes.

For years the American Medical Association had distrusted these plans (many medical politicians thought they were "socialistic"), but in 1949 it began plastering the countryside with advertisements extolling them: "The Voluntary Way Is the American Way." Today the Blue plans enroll 127,000,000 of us.

Yet it's now quite clear that they've failed to do what was promised for them and provide a substitute for socialized medicine.

In the first place, as I've just pointed out, they're involved in the same price squeeze as other medical costs. Blue Cross does at least do the things it promises to do; the only trouble is that more and more Americans can't manage the steadily rising premiums. If it's true that 127,000,000 are enrolled in these plans, it's equally true that another 50,000,000 are not. These include precisely those who need medical insurance most—the poor who can't afford it, and the elderly who, in accordance with orthodox insurance-company thinking, are most likely to be ill and are therefore excluded as "poor risks."

Furthermore the fact that the Blue plans pay on the average only one-third the medical costs of their members means, in actuality, that the higher your costs are, the smaller the share they'll pay.

CHARITY CARE

Point three of the American Medical Association's "Six Point Health Program for Older Citizens" proposes: "For those who do not have sufficient resources of their own, indigent medical care programs should be supported with adequate state and local appropriations." What this means, of course, is that once medical bills have pauperized us we'll qualify for free care.

But a further objection to this demeaning (and unAmerican) approach is that it's capricious in its workings. Witness for example a recent case in Luzerne County, Pennsylvania, where all ten members of a family were stricken with scarlet fever.

They were on relief, and the welfare department was allowed to offer only $6.50 for their doctor's bill. Result: no doctor. More than fifteen doctors were asked to help, and eight to ten health and welfare agencies; they all refused. Finally a doctor in the next county heard of the case and drove thirty miles to treat the sick family. But only after eight days had passed.[10]

Dental care is excluded.[12] So too, usually, is psychiatric care.[13] Millions have medical insurance through collective bargaining—that is, it's tied to their jobs—and when they change jobs or get laid off their insurance lapses,[14] just when they need it most because they no longer have a steady income.

Ideals Abandoned

Moreover, once organized medicine took over the Blue plans it began to run them on AMA principles. In the words of Leonard Woodcock, vice president of the United Auto Workers, the Blue plans "capitulated completely to [those] elements in organized medicine which, less than twenty years ago, tried to strangle Blue Cross and Blue Shield in their infancy. . . . A brief period of brave experimentation [gave] way to premature senility."[15]

Back in the thirties when the Blue plans were small and despised they were humanitarian in intent. They were designed for the poor, and participating physicians reduced their fees for members of the plans. Today, Blue Shield especially is run like the insurance companies; the element of sacrifice has been lost.

In fact, nowadays many doctors *raise* their fees when they find that a patient has Blue Shield coverage. A patient who thought his insurance covered all his expenses finds it covers only a portion. The AMA not only insists on fee-for-service remedial practice, it also maintains that fee schedules are "undemocratic." If therefore Blue Shield announces it'll pay so much for an appendectomy, and so much for a fractured arm, this announcement bears no necessary relation to what your doctor will actually charge.

Another widespread abuse is overutilization of hospital beds. Many doctors admit patients to hospitals who could just as well be treated out of hospital, except that their insurance is good only for inpatient treatment.[16] This contributes in a major way to the current shortage of hospital beds. It also makes Blue plan premiums go up, since hospital care is the most costly element in medical care.

The extent of this can readily be discovered; one has merely to apply fifth-grade arithmetic to the Consumers Price Index to learn that between 1951 and 1959, for instance, all costs went up 12 per cent, all medical costs went up 36 per cent, hospitalization costs went up 65 per cent, and group hospitalization rates (Blue Cross premiums) went up 83 per cent. The disparity between these last two figures shows the degree to which rising Blue Cross rates express overutilization as well as rising hospital costs.

The abuse of overutilization is, of course, inevitable in any scheme that isn't comprehensive, that pays only part of the cost of illness.

Labor's Attitude

The Blue-plan experiment was aimed especially at labor, the best-organized and most vocal of the groups favoring socialized medicine. A great proportion of the people with Blue-plan coverage get it through collective bargaining. Labor was disenchanted with the Blue plans from the beginning; now, after years of trial, it's more so.

Nelson Cruikshank, of the AFL-CIO's Washington office, for years has been careful to describe Blue Cross and Blue Shield as only "the next best thing" to socialized medicine,[17] and his office has kept on working to get the government involved in medical costs. Other labor leaders echo this attitude. Walter Reuther has dismissed collectively-negotiated insurance coverage as "money we could bargain for"[18]—that is, in settling

for fringe benefits, labor gives up some of its power to push for a wage raise. Such insurance is, in fact, money out-of-pocket for union members; and the unions are not convinced they're gaining very much by spending their money in this fashion.

In Detroit, the United Auto Workers have taken leadership in organizing a consumer-run cooperative medical plan to give comprehensive care to all comers on a preventive basis. The United Mine Workers have set up their own chain of hospitals—over the agonized protest of organized medicine—and have revolutionized the health of mining communities all across the nation. New York City unionists are talking about doing the same thing; the Steelworkers, too, are thinking about building their own hospitals. The Longshoremen and dozens of other unions have built their own clinics.

Labor has been forced into the medical business by government inaction and AMA recalcitrance. Naturally, it feels resentful.

If resentment is a proper sentiment for labor to feel about the lack of socialized medicine in America, how much more proper it is for those millions of others who don't belong to unions, or whose unions are too poor to afford their own medical programs.

3: THE RIGHT TO GOOD HEALTH

MEDICAL CARE is now one of the fundamental essentials of life, along with food, clothing, and shelter. People think of it as not just another need, but a *right* that members of the human family ought to guarantee one another in any civilized social system.

This is the most elementary reason for the demand for socialized medicine.

It's a reason which didn't exist, say, a century ago. Until recently medical care was no more than an art, often an ineffective one. But the technological revolution of our times has transformed medical care into a science that has altered the whole texture of our lives. The Department of Health, Education, and Welfare reports that in the 1880's, 86 per cent of all American deaths were of persons under 65. Today that age group accounts for only 44 per cent of all deaths.[19] Scientific advances have given medicine a new social relevance.

Yet our arrangements for the organization and distribution of medical services are still those which were appropriate to the medical technology of a hundred years ago. Formally, our society continues to categorize medical care as a luxury product which only the rich may have in abundance.

Cadillacs and Medical Care

This viewpoint is defended, too, by people with special interests to protect. At a recent intercollegiate colloquium on socialized medicine, a spokesman from the Health Insurance Association demanded, "Why should we use tax money to buy everybody health insurance?" Indignantly, he went on to say, "We might just as reasonably buy everybody a Cadillac. It's the same argument."

This remark did more to win an uncommitted audience to socialized medicine than all of my remarks put together. Because, of course, almost no one any longer categorizes medical care with Cadillacs. Yet the HIA man was doing no more than defending the status quo. His comparison was simply an extreme, and ill-advised, but perfectly accurate statement of the official attitude toward medical care which still

governs the way in which it's administered.

It's another case of science advancing faster than social institutions.

The Medical Revolution

Since most of us were born in the age of modern medicine, we don't usually realize how very recent (as history goes) are the medical miracles we take for granted.

Surgery in the modern sense, for example, didn't begin until October 16, 1846. On that date, in the Massachusetts General Hospital in Boston, Drs. Morton and Warren performed the first operation under anesthesia. Again, it was only in 1849 that a young Hungarian, Dr. Ignaz Semmelweiss, first realized that childbed fever was spread by the contaminated hands of examining physicians. Dr. Semmelweiss devoted his life to trying to make doctors wash their hands; he was jeered at and ignored, and finally died in a madhouse of frustration: For another generation, millions of mothers died unnecessarily.

Still again, germs were postulated by the Frenchman Louis Pasteur only in the 1860's; an English Quaker, Dr. Lister, then applied the germ theory to surgery and began developing modern techniques of antisepsis; a German, Dr. Robert Koch, verified Pasteur by distinguishing for the first time a specific disease germ, the anthrax bacillus, in 1877. But it wasn't till the close of the 19th Century that these discoveries were generally accepted. Hospitals continued to be charnal houses stinking of gangrene; in the War Between the States as many men died in hospitals as died on the battlefields.

This account can be continued almost indefinitely. A technique for successful Caesarian section was not perfected until 1876, by the Italian Dr. Porro. Stomach operations became possible only in 1881, through the work of two Austrians, Drs. Billroth and Woefler. This century has brought us brain surgery, radiology, insulin, antibiotics, blood banks, the Salk polio vaccine, heart surgery, and now kidney transplants. New discoveries are coming at an ever-faster pace, with a cure for cancer now possibly just around the corner, to be followed by further developments at which the imagination boggles.[20]

What 'Socializing' Means

The expression "insurance" is a misnomer as usually applied to suggestions for public payment of medical costs. Harry Truman's proposal for "national health insurance" wasn't really a proposal for "insurance"; neither was the Forand Bill adding medical benefits to Social Security.

Insurance is sold on a basis of calculated risks, and benefits reflect the size of your premiums. Truman's plan, the Forand Bill, and all suggestions for socialized medicine are based on a very different idea. "Premiums" are collected in the form of taxes, more or less on the basis of income; benefits are distributed more or less as they're needed. Unlike conventional insurance, the principle here is "from each according to his ability," as the old Socialists put it, "and to each according to his need."

It's begging the question to attack such an approach to our medical needs on the grounds that it's "socialistic" (as indeed it is). For this is exactly how we now approach the problems of public education, of police and fire protection. Many citizens never use the public schools; their houses aren't burgled and never catch on fire; nonetheless they pay taxes for these basic public services. Some needs are so basic, so uni-

versal, and so urgent, that as a matter of course society meets them in a socialistic way.

The social relevance of medical care compares to that of police and fire protection or public education. Therefore it is, like them, a proper object for socialization—not merely by the standards of visionaries and social reformers, but by everybody's standards. That's why the fact that people *need* medical care is the most elementary, though not the most urgent, argument for socialized medicine.

4: INEQUITY

A FURTHER argument for socialized medicine lies in the fact that our present system of medical care is inequitable. Most of the civilized world now uses government and tax mechanisms to distribute medical costs and services fairly. Americans do not. The result is human suffering.

The costs of medical care in the United States are distributed in such a way that one family in fifty now spends more than half of its income on health.[21] The blessings of modern medicine, in this country, bring with them the threat of bankruptcy.

What's it like to belong to the one family out of fifty with catastrophic medical expenses? Let's look at a couple of case histories.

Two Case Histories

Throughout most of 1958, "M.W.," a 43-year-old accountant living in Boston, was bothered by a cough. Finally he went to a doctor with it, and in due course was told he had lung cancer.

M.W. was lucky; he sought help before his condition became incurable. He went to a hospital and spent a week or so having tests; then he was operated upon, had a lung removed, and spent another month in the hospital recuperating. The doctors told him to go home, stop smoking, take a vacation for half a year, and report back for frequent checkups. Today he's back at work and relatively healthy.

Many of us—perhaps most of us—wouldn't have gone to a doctor until too late. A persistent cough is the sort of thing one ignores when money's hard to come by and medical expenses are high. But M.W. didn't have this problem. "I was earning $6,000 a year and I had Blue Cross and Blue Shield," he says. "Also I'd had a small inheritance, so that I owned my house outright and had another $7,000 put away to educate my three sons. I never worried too much about medical bills."

He figures that in eleven years he'll be out of debt, unless he gets sick again.

His $7,000 savings were eaten up by hospital bills, surgeons' bills, radiologists' bills, special nurses, operating room fees, diagnostic procedures, and drugs. He calculates that Blue Shield paid exactly 4 per cent of the costs he had supposed it covered. But aside from that, for the better part of a year he wasn't able to work. He put a mortgage on his house; and, he points out, "now, before that's paid off, I'll have to mortgage it again to give my kids the education I've always promised them.

"But," he goes on, "I'm still lucky. For one thing, I had a house to mortgage. And for another thing, I'm earning money again. What if I'd been permanently disabled?"

For an answer to that question let's look at another case. "L.B." was a 37-year-old machinist living in Milwaukee, married with two children. In 1956 he was crossing a street one evening on the way home from work, when a car struck him and broke his hip. The driver was at fault but had minimal insurance and too few assests to be worth suing.

L.B.'s fractured hip infected (osteomyelitis): He spent the next three years in a plaster cast from chest to toes, and at this writing has had more than twenty operations. He'll never walk again; he'll be in pain for much of the rest of his life; he'll need further operations approximately once a year.

But L.B.'s tragedy isn't only medical, but financial. His bills are astronomical; so far he owes the hospital alone more than $25,000. His savings have vanished. His health insurance, as always in such cases, was a cruel disappointment. His earnings, of course, have stopped for good; and he worries about his family day and night.

Health and Wealth

Our present system of medical care, then, means catastrophe to people of any but the highest income level who come down with prolonged or chronic illnesses. But it's unfair not only in its distribution of medical costs but also in its distribution of medical services.

One-fifth of the Amercan people earn less than $2,000 a year; they spend a median of 10.2 per cent of their income if insured, and 4.8 per cent if uninsured, for medical care that's almost always inadequate in either case.[22] For the poor, by and large good health is a matter of luck.

The government doesn't collect statistics on the relationship between health and wealth in our democracy. But this relationship may be glimpsed in the notorious gap between the official morbidity and mortality statistics for "whites" and for "nonwhites." To take just two examples:

In 1957 the death rate for infants under one year of age, per 1,000 live births, for "whites" was 23.3. For "nonwhites" it was 43.7.[23]

In 1953 the death rate from tuberculosis per 100,000 people for "whites" was 9.1. For "nonwhites" it was 35.0.[24]

"Nonwhites" are of course mainly Negroes. But these figures don't vary much between the South, where medical care is segregated, and the North, where it isn't. Therefore they express not the

DOCTORS AS BUDDING BUSINESSMEN

Once upon a time, medicine attracted the kind of people who if they hadn't decided to become doctors, would have become teachers, ministers, social workers. Now, as the doctor's role as a private businessman becomes progressively more outdated, this is less and less the case.

Professor E. Lowell Kelly of the University of Michigan demonstrated this by giving a series of motivation tests to several medical-school classes. He found that today's medical students "are persons who, if they were not becoming physicians, would be planning to become manufacturers, big businessmen, production managers, engineers. They are not the kind of people . . . . interested in doing something for the good of mankind. As a group, the medical students reveal remarkably little interest in the welfare of human beings."

Psychologist Kelly concluded from his tests that "the typical young physician has little . . . sensitivity to or feeling for the needs of the community, and is generally not inclined to participate in community activities unless these contribute to his income."[26]

effect of segregation, but of discrimination. In the North as in the South the Negro is herded into slums, is the last to be hired and the first to be fired, is given the dirtiest and lowliest and most poorly-paid jobs. The "nonwhite" category is therefore made up of poorer people on the average than the "white." And these figures show that one consequence of poverty is a lower life expectancy.

When you recall that after all, the "nonwhite" category does include some well-to-do people, and the "white" category includes many who are very poor, it becomes plain that damning as these available statistics are, they're only a dilution of the true figures on health and wealth, which must be far worse.

Fear, Unhappiness, Resentment

A byproduct of the inequities in our present system is public resentment of doctors; which in turn has its effect upon the quality of medical care.

Recently I was present in a tenement in a New York workingclass district when a little girl fell down a flight of steep stairs. The mother ran after her, picked her up, saw she was unhurt, and began slapping her across the face. "Dammit," cried the mother, "what are you trying to do, break a leg and get us a doctor bill? You know we can't afford an accident!"

Three years ago Elmo Roper and his pollsters did a nationwide survey: They went around asking whose bills people resented most. Among the well-to-do, doctors placed a close second after plumbers. And among everyone else doctors won hands down. Landlords, traditional oppressors of the downtrodden, came in second. Still more interesting, people in small towns (where patients are likeliest to be socially acquainted with their doctors) were far more convinced that doctors overcharge than were people in big cities. Commented Roper: "The small town is—or used to be—the citadel of that beloved stereotype, the 'family physician.' . . . Something has . . . now gone amiss with this piece of folklore."[25]

Doctors presumably enter their profession at least in part for altruistic reasons, out of a wish to bind up wounds and help suffering humanity. My own (extensive) experience of the medical profession persuades me that the motives of most doctors are in fact far nobler than most of us are ready to grant. Yet they've replaced landlords in the popular imagination, as the predators most worthy to be feared. This is a direct consequence of the unfair way in which medical costs and services are now distributed.

5: PREVENTIVE CARE

WHAT IS THE impact of the system of privately-financed medical care on all the rest of us? Those of us with average incomes, who have not (so far) suffered from catastrophic illness?

In the first place, since medical care is something we cannot under any circumstances do without, we sacrifice other expenses so that we can get the help we need.

As medical costs keep on accumulating first the car gets sold, then the house, then sons are withdrawn from college. To say that most Americans can afford medical care, is to say only that they choose to give up everything else if need be in order to afford it.

In the second place, people don't go to doctors until they're absolutely sure they have no alternative.

This is a point of profound significance. For as everybody from the AMA on down will tell you, the ideal form of medical care in the 20th Century is preventive care. In the long run, it's also the least expensive. Cancer and many other diseases can often be stopped or cured if they're caught in time. Heart and kidney troubles can often be forestalled by proper diet and other inexpensive procedures. A host of problems can be readily corrected while they're trivial, which if uncorrected will develop into major illness. In other words, the best and cheapest way to stay well is to go to a doctor not when you're ill, but when you're healthy; to get a complete medical checkup every year.

But who among us has the wisdom and fortitude to spend, year after year, part of our hard-earned money—no doubt earmarked for other important purposes—on expensive tests, with a likelihood of being told at the end that we're perfectly healthy?

Our present system of medical care is not preventive but remedial; that is, we wait until we're sick to go to the doctor for a remedy, and pay him so much for each thing that he does for us. Modern medical technology tells us that there's a better way of doing things. But we're stuck with an archaic and outdated system of paying individual doctors, a factor which is steadily aggravated by rising medical costs, and which means that we can't take full advantage of what medical technology offers us. Nor shall we, until there's a drastic and basic change in the way medical care is distributed in this nation.

It's worth noting here that Sweden, which has had socialized medicine for many years, has at the same time (1) better morbidity and mortality statistics than most other nations (including ours), and (2) *less* doctors per population than most other nations (including ours). Swedish medical care has been stabilized on a preventive basis, which means the Swedes save money by having less illness and, consequently, by needing fewer medical facilities and doctors. To those who argue that socialized medicine means spending more money on medical care than is now spent—as would undoubtedly be the case for a number of years while we caught up with the backlog of uncared-for needs—the Swedish experience shows that in the long run socialized medicine is less expensive than any other kind.

Measuring Needs

One result of the present system of medical care in America is that we not only cannot measure our real health needs, but further we mislead ourselves by trying to measure them with yardsticks which in the last analysis are

PREVENTIVE vs. REMEDIAL CARE

The superiority of preventive over remedial care was dramatically shown in a 1957 study of 800 Baltimore residents. Each was asked to estimate the state of his own health, and then was given (free) a complete clinical examination. Findings:

None of a group of patients with disease of the prostate was sufficiently aware of the condition to report it. Of those with cataract, but not blind, 80 per cent were unaware of their predicament. Of those with hypertensive heart disease, 60 per cent didn't know about it.[27]

callous and inhuman. A prime example of this is the American Medical Association's attitude toward the doctor shortage.

Back in the early Thirties, the AMA decided there were 25,000 too many doctors. It persuaded no less than twenty-two state legislatures to ban the licensing of foreign physiicans. It persuaded a number of medical colleges to reduce their enrollments.[28]

Today there are *more* doctors per population than there were then (though the proportion is now going steadily down) yet the AMA admits there are too few doctors.

Change of heart? Not on your life. What has changed is the general economy. In the early Thirties nobody went to a doctor until he was on his last legs; today more people are not quite so badly off.

The AMA does not measure need. It measures the number of prosperous practices. When times are bad and doctors are broke, it finds we have more doctors that we "need"; when times are good, it finds we have too few doctors.

How many doctors does America really "need"? Nobody knows—but of one thing we can be sure: The AMA's standard of measurement is totally irrelevant.

The same kind of thinking crops up when we study the hospital shortage. It has been estimated that we need one billion dollars just to modernize existing hospitals.[29] Other figures show that new hospital building isn't keeping up with rising population, and besides more people are using hospitals more often.[30] But the trouble with all these figures is that they're based on supply and demand in a situation where people's personal finances are an unknown factor.

What all this adds up to in human terms is shown by the experience of the British when they first set up their system of socialized medicine. During its first year the British Health Service prescribed *eight-and-a-quarter million* pairs of eyeglasses for a population of about fifty million. There are similar figures for dentistry.[31] Glasses and dental care are, of course, things one does without when money is hard to come by. Assuming that one Briton out of three needed glasses (probably an exaggeration) these figures prove that at least half the people who needed glasses were doing without, and doubtless suffering from headaches and inefficiency as a result. It's ridiculous to claim that all these people literally couldn't afford glasses; either they had chosen to spend their money on other things, or they weren't aware of their need. How many such hidden needs are now concealed by this country's emphasis on fee-for-service remedial medicine?

Human need is not bound by finances, nor measured by the law of supply and demand. We cannot possibly know what our nation's actual medical needs are; we know only that they're not being met, and that under present circumstances there's no way of even measuring them.

6: THE OPPOSITION

What Ails Doctors?

The opposition of American doctors to socialized medicine verges on the fanatical. But the last reason they cite for their opposition is in fact their first and greatest—the dread that socialized medicine will topple them from their present perch on top of the prosperity heap.

The fact that in other countries doctors do not oppose socialized medicine the way they do here, seems on the face of it to relate to the fact that in other countries doctors never had it so good. In Britain, for instance, the average doctor is actually making more money now than he did before socialized medicine.[32]

One privately-practicing American doctor out of eight makes $30,000 a year or more. Four out of five earn more than $10,000 a year. In 1955, according to the magazine Medical Economics, the median income for private doctors was $16,017 before taxes; for all specialists it was $18,010. And this represents a rise of 306 per cent over 1939.[33]

Yet—as I hope I've made clear—rising medical costs are not due to the fact that doctors are pirates. Most of them aren't; and even if they were, this could represent only a very small portion of the total picture of medical costs.

Also, believe it or not, there are some arguments that justify doctors in getting this kind of money. For one thing, it represents an average work week of slightly more than sixty hours. If the typical doctor's income is calculated in terms of hourly rates with overtime, and doubletime for Sunday work, it comes out to a base pay of $4.13 an hour. This compares with $4.25 an hour base for union bricklayers in New York City. True, bricklayers don't manage to work sixty hours a week; they're lucky to work forty hours. But then if bricklaying is a skilled craft, medicine is more of one.

Furthermore, these figures represent doctors' incomes during their payoff years. Before a doctor makes this kind of money he must spend four years in college, four more years in medical school, and a year as an interne. The last year he gets subsistence wages; the other eight years he pays out money. To become a specialist he must then put in three to seven more years of study as a resident. Then he still has to set up practice, often buying it; he has to buy equipment; he has to wait for patients. If he's a surgeon he's already nearer forty than thirty, with a prospect of early retirement because of the stren-

WINNOWING OUT THE UNDERDOG

If doctors as a group seem singularly blind to the problems of the underdog, one reason is that young people from have-not families find it almost impossible to become doctors.

It costs about $47,000 to educate a general practitioner, and $64,000 to educate a specialist. A bit more than half of this is met by college endowments, fees from hospital patients, etc. The rest has to be raised by the doctor-to-be and his family.

This means trouble for all but the wealthiest. More than half of 1959's medical school graduates were in debt; 20 per cent of them owed nearly $5,000. Many medical students are supported by working wives, or by parents who sell their homes or make other sacrifices on a similar scale. Those whose families aren't at least well-to-do usually can't even make a try at medical training; 45 per cent of U. S. medical students come from families earning more than $10,000 a year.

In recent years applications to medical schools have gone steadily down. The AMA has done a good deal of viewing-with-alarm over this fact. But at the same time it opposes the idea of government assistance to the cost of medical education—thus maintaining the social status quo, as well as contributing in a major way to the doctor shortage it supposedly laments.[34]

uous nature of his specialty. He'll probably be well past forty before he gets out of debt.

These are the facts of a doctor's economic life, and they're his justification for a high rake-off when he finally gets going. And if he hates and fears socialized medicine, it's because he believes a government-administered system would fail to understand these facts, and would seek to slash costs by cutting his income.

Advocates of socialized medicine need to provide an answer to this fear. And there is an answer, one that makes good sense and carries inherent conviction. Which is, that under socialized medicine medical education will not require the extreme sacrifices it now requires, and there'll be no more buying and selling of practices and waiting for patients. And that until such a state of affairs has come to pass, doctors should continue at a high average income level.

AMA 'Democracy'

Many doctors are disinterested enough to favor socialized medicine in spite of fiscal fears and the official position of the American Medical Association. How many? Impossible to tell; fighting the AMA requires of doctors a degree of personal courage possessed by few people in any walk of life. But one indicator is a report from Representative Aimé Forand, that letters from doctors regarding the Forand bill ran eight-to-one in favor of it. This at the very time when the AMA's Washington lobby was spending more money than any other lobby, mostly in fighting the Forand bill.[35]

The AMA's demagogues have been in the forefront of those who wave the flag to achieve selfish ends. Socialized medicine, they say, is obviously socialistic, the very term says as much. (Literally, it means medicine socially organized.) And socialism, they say, means communism. (Never mind that in every country the communists have seized, the democratic socialists have been the very first people they've murdered.) Therefore to favor socialized medicine is to favor communism—or, at very least, it's to be unAmerican.

While this exercise in illogic contains a certain humor, to appreciate its true savor one must contemplate the internal structure of the AMA. It comes as near to the communist principle of "democratic centralism" as anything in America. AMA "democracy" has fairly been likened to a system in which our state legislatures would elect Congressmen who in turn would elect the President. This on paper is how it works in Russia; and, as in Russia, it's a system that's readily manipulated. The AMA is in fact run by a little clique of people whose main characteristic is that, unlike most doctors, they have time to spare for medical politics. The typical AMA activist is likely to be a man only peripherally interested in practicing his profession.

The young doctor with time for medical politics gets his start on one of the committees of his county medical society. If he works hard and behaves himself and shows he has the proper viewpoint, presently he'll get tapped for higher office. Increasingly he confines his social orbit to other AMA activists, among whom he must show himself, consistently and over a period of years, to be devoid of heresy, immune to new ideas, and zealous in the cause of AMA righteousness. Finally he can hope for the reward of office in the national organization.

Lamentably, medicine is a profession in which by necessity the young must be at the mercy of the old. A new doctor depends on established doctors for hospital privileges, for referrals, in short

for success. Even under an ideal system of socialized medicine, the established physicians would obviously have to pass on the competence of new doctors and decide, for instance, which operations they'd be allowed to perform. At present this fact is sometimes used to suppress potential rivals or express social prejudices; and it's almost invariably used to punish dissent.

Red Herrings

In opposing socialized medicine the AMA uses a number of arguments which make good rhetoric but which, upon examination, turn out to be empty, malicious, or downright silly. Its argument about "compulsion" falls in all three categories.

There are two faces to compulsion, by AMA reckoning. First, "compulsory national health insurance" (socialized medicine) is unAmerican because it compels everybody to pay taxes for medical care whether they need it or not.

This point harks back to the question whether medical care should be categorized with Cadillacs or with public education. When we think of it as a basic social service, the question of "compelling" people to pay taxes for it becomes ridiculous. After all, it's also unfair to collect compulsory school taxes from people without children. Same argument.

Moreover, in making this point the AMA contradicts its own official espousal of the superiority of preventive-care-when-you're-healthy over remedial-care-when-you're-sick. If you think in terms of preventive care, then medical help is not just an occasional need, but a year-in year-out *right* of all citizens.

The second face of compulsion, according to the AMA, is that socialized medicine means compelling people to go to socialized doctors. (In fact, they'd probably have to be compelled not to.) Socialized medicine, the AMA claims, will undermine the right of free choice of physican.

Now in fact, free choice remains perfectly free under socialized medicine in Britain, New Zealand, Sweden, and many other countres. That is, people

ETHICS—AMA DEFINITION

The county medical society in Houston, Texas, has been vigorously opposing efforts to expand the Baylor University College of Medicine and build a new hospital at the Texas Medical Center.

Recently a Dr. Abel A. Leader decided he'd had enough; in a speech he declared that he could not "in clear conscience" go along with his society's obstructionist tactics. He pointed out that $15 million has long been available for the proposed expansion, but that the medical society has kept it from being spent because of its insistence that its members control all hospitals.

Dr. Leader said that a "barbaric state of overcrowding" in existing hospitals has led to an increase in infant deaths. He added that any doctor who would "knowingly do injury to a medical school differs little from the man who would beat his parents."

For thus exercising his constitutional right of free speech, Dr. Leader must now face a secret trial before a medical-society committee. If found guilty he may be expelled for "unethical" conduct. If this happens he won't be allowed to admit his patients to hospitals or consult with other doctors; in other words, he'll be out of business.[36]

can choose freely between various Health Service doctors, or they can choose to see a private practitioner.

The argument of free choice is itself one of the smelliest of red herrings. The AMA claims that free choice is one of the priceless freedoms of the American heritage. In fact, it's no more than a trade rule to keep doctors from grabbing each other's patients.

The fact is that people without special medical training aren't qualified to know which doctor they should choose. When you're sick, how can you be sure what's wrong with you? and even if you are, do you know how to weigh the training of a number of doctors and pick the one most competent to deal with your problem?

Someday I'm going to ask an AMA politician whether he likewise demands for his children the right of free choice of schoolteacher.

Doctor of the Year

A typical AMA gimmick is the annual "election" of a "doctor of the year" who's then publicized by advertising and by the placing of articles about him in leading magazines. What's the public-relations function of this device?

As you probably recall, the doctor of the year almost always turns out to be a silver-haired country general practitioner. There are still a few of them left, and the AMA invariably finds one who's kindly and fatherly and probably earns about one-tenth of what most American doctors earn.

This gimmick ties in with the myth of the country GP, the "oldtime doctor," now as widely believed in as was any fabulous creature of pagan antiquity. He works eighty hours a week, yet he's always kind and patient. More unlikely yet, he never collects bills. He'll presumably be displaced by socialized medicine.

Actually, as any doctor can tell you, if there ever was such a creature he went out with the horse and buggy—and besides, he practiced horse-and-buggy medicine. If he still exists anywhere, his patients are people who can't afford to go to specialists. Most certainly he doesn't have time to be active in AMA politics.

Lines of Defense

The AMA can be described as having three lines of defense in its approach to socialized medicine. But this describes the fact, not the intention. The AMA does not think in terms of strategic withdrawal to previously-prepared positions; it thinks in terms of blind massive resistance to any and all proposals for change. In the words of Dr. Ernest B. Howard, assistant executive vice president of the AMA, "The surest way to total defeat is to say, 'We are now going to sit across the negotiating table. . . .' "[38]

But in fact when massive resistance fails, a second argument remains. This is the argument that private insurance can do the job better. And when this, too, is defeated, and a program for government intervention seems unavoidable, the AMA still has one argument left. This is the argument that if tax money *must* be used to underwrite medical costs, it should do so in a way that doesn't interfere with the status quo. Thus the ultimate impact of AMA politicking is toward creation of a system in which tax money will be used to underwrite private fee-for-service remedial medicine.

The Insurance Industry

The relationship of the AMA and the insurance industry is hard to pinpoint, but there's no doubt there is a relationship. In early 1959, when organized medicine was just starting to get scared about the Forand bill, its arguments were bolstered when by a strange coincidence one insurance company came out with a new (and expensive) policy that almost duplicated the bill's provisions, and was aimed especially at old people. The company peddled its policy in full-page newspaper advertisements, in which it praised itself and the insurance industry for offering a magnificent new service to the American people. (When offered by the government, this same service is somehow much less magnificent.) AMA lobbyists in Washington pointed to this policy as proof of their argument that government financing wasn't needed.

At about the same time, the National Association of Life Underwriters came out against the Forand bill, and insurance men were urged to write their Congressmen.

Then next year several tame politicians proposed, in all seriousness, that instead of the Forand bill the government should give money to the private insurance companies so that they could offer the same benefits at the same cost but on a "voluntary" basis. They suggested, in other words, that taxpayers should help support the insurance industry's political lobbies, advertisements, and executives with plush expense accounts.

This suggestion is most easily answered in terms of dollars and cents. Nelson Cruikshank of the AFL-CIO has calculated on the basis of official insurance-company reports that in 1958, the companies collected a total of $1,235,000,000 in health insurance premiums, and paid out $694,373,000. This means that out of every dollar you paid them in premiums, they spent 43c on "overhead," "reserves," etc., and only 57c was left to pay your medical bill. The companies can get away with such figures because they select their own customers, and reject "bad risks"; that is, the more likely you are to get sick, the less likely you are to be allowed to buy insurance, and the more you'll pay for it. The nonprofit medical plans do much better; they spend at most only about 10c of your dollar on operating costs. But Social Security spends only about 2c out of the dollar on operating costs.

Holy of Holies

The AMA becomes most hysterical when proposals for change touch upon payment methods. For instance in the "Medicare" program for military dependents the AMA fought hard for a system under which beneficiaries could go to any private doctor of their choice, and only very bitterly conceded that this system should include a fee schedule, governing what doctors would get paid for each procedure.

The government now renegotiates these schedules periodically with each separate state medical society, which is interesting in that it turns organized medicine into a collective bargaining agency. This is a legitimate role for the AMA, and one that will become more important as we move nearer to socialized medicine.

In the case of the Forand bill it has been proposed from the very beginning that doctors should be paid according to the present antiquated system of fee-for-service piecework remedial medicine. This basic concession is lamentable in its impact on the cooperative and labor medical plans, where preventive care is distributed by salaried doctors and the whole set-up is deliberately one in which payments are not tied to specific procedures. An obvious solution is to permit Forand bill beneficiaries to choose to take their benefits in the form of regular monthly

payments into any nonprofit insurance scheme they choose.

This proposal touches fundamentally upon the organizational drawbacks in American medicine, and therefore sets a precedent which will be very important when socialized medicine is enacted. It's an excellent example of the kind of thing advocates of socialized medicine must get behind, as they decide what attitude to take toward proposals for half-a-loaf government programs.

Allies

In its fight against progress the AMA does not stand alone. Beside it, shoulder to shoulder, stand the insurance industry and the pharmaceutical industry, both with enormous economic resources. Behind it stand all the usual forces of social and fiscal conservatism in this nation, such as the National Association of Manufacturers and the National Chamber of Commerce.

But these forces have been successful in the past, in holding back the tide of socialized medicine, not because of their own strength but because of the peculiar structure of politics in the United States. Since the late Thirties Congress has been dominated by a coalition of Republicans and conservative Southern Democrats who, between them, have squashed not just socialized medicine but every other proposal for basic social reform. The role of the AMA, politically, has been to supply the conservative majority in Congress with the excuses it needs to follow its inclination and vote against socialized medicine.

This means that politically the fight for socialized medicine is tied up with the fight for political realignment; that is, the fight to achieve a division of political forces in this nation such that it will be possible to cast a vote for social reform. At present a vote for a liberal or labor-sponsored Congressman is a vote for the Democratic Party in most cases, and it serves to install Southern reaction in powerful committee chairmanship. In common with advocates of dozens of other social reforms, people who want socialized medicine must be politically preoccupied with, for instance, such matters as the seniority system by which Congress chooses its committee chairmen, and must favor candidates who are pledged to end it. At present it's possible only in a very limited sense for a citizen to cast a vote for socialized medicine.

Indeed this is in all probability the only reason why America has not long since had socialized medicine. So far as it's possible to tell, it seems likely that the majority of the American people are in favor of socialized medicine. In fact, the fight for socialized medicine throughout this century adds up to a classic example, of the way in which the wishes of the majority of the people can be consistently frustrated and stymied by a well-organized moneyed minority. As shall be shown in the next chapter.

7: HOPE DEFERRED

"Withhold not good from them to whom it is due, when it is in the power of thine hand to do it. Say not unto thy neighbor, Go, and come again, and tomorrow I will give, when thou has it by thee."

— Proverbs 2:27, 28

The industrial revolution of the last century brought forth a new class of dispossessed people, who in every nation expressed themselves through new mass movements—the cooperative movement, the socialist movement, the labor movement, and so forth. Out of this ferment appeared a new notion of civic responsibility—that men have it in their power to create a less imperfect social order, and that it's criminal and sinful for them not to do so.

In the United States, socialized medicine was one of those proposals of the early Socialist Party which, like its proposals for Social Security, child labor laws, minimum wage and workman's compensation, were quickly taken up and pushed by organized labor and by humanitarians of all political parties. Like those other proposals it soon found a wide popular response.

So much so, that on the eve of World War I enactment of a national health "insurance" plan seemed imminent. In 1916 the AMA was told by its Board of Trustees that "the time has come when we can no longer resist the social movement, and it is better that we should initiate the necessary changes than have them forced on us." In 1917 the AMA passed a resolution looking toward the adoption of compulsory Federal medical insurance, and detailing its ideas on how such a system should work.[39]

The war thrust socialized medicine into political limbo; the "normalcy" of the Twenties kept it there. The AMA settled into its posture of last-ditch opposition, from which it has yet to budge. (It also decided that it opposed workman's compensation and "compulsory" smallpox vaccinations.) None the less, the issue of socialized medicine remained alive and popular. Books were written about it, high schools debated it, Congressmen promised it to their constituents. The Milbank Fund, a foundation supported by the Borden Milk Company, conducted pilot studies that showed the desirability of publicly-supported preventive medicine. After Roosevelt was elected in 1932 it was generally expected that he would include socialized medicine in his suggestions for the new system of Social Security.

But organized medicine fought back hard and successfully. The Milbank Fund was brought to heel by a physician boycott of Borden's Milk. The members of Roosevelt's Committee on Economic Security were bombarded with letters from physicians all over the country, and from those of their patients and friends whom they could influence. To the Committee's members, Social Security itself seemed a drastic-enough innovation, of whose popularity they couldn't then be sure. In the end, they left socialized medicine out of the Social Security Act.

The Recent Period

In the late Thirties Senator Wagner and others proposed several very modest laws for government-financed medical care. It was by then too late for these proposals to have much real chance, since the period of New Deal reform was over and the present era had begun, with Congress controlled by a conservative alliance of Republicans and Southern Democrats. However, this was not yet generally apparent. The AMA felt it had to fight back by "going to the public."

To this end it set up the National Physicians' Committee for the Extension of Medical Service. This Orwellian name supposedly covered the fact that the committee's real function was to oppose extension of medical services in every way possible. In its first official statement, addressed to American doctors, it candidly declared that its intention was "to make enough noise so that Congressmen will find some other worm besides 'free medical care' with which to feed their peeping constituents." By 1948 this high-minded committee had become the biggest lobby

in Washington, and was spending millions on advertising.

Again, reform of medical services was postponed by war. But in 1942 a poll by Fortune magazine showed that 74.3 per cent of the American people believed that "the Federal government should . . . collect enough taxes after the war for medical care for everyone who needs it." Those who distrusted this finding (having in mind, no doubt, Fortune's notorious predilection for social reform) were comforted—but only slightly—when next year a Gallup poll showed that only 59 per cent of the people favored socialized medicine.

In 1948 the roof fell in on the AMA. First, the example of socialized medicine in Britain captured the imagination of millions of Americans. Second, Harry Truman was reelected on a platform that included national health insurance. Third, the AMA's lobby, the National Physicians' Committee, was utterly discredited when it offered "cash prizes" (bribes) to newspaper cartoonists who could get pro-AMA cartoons published. Fourth, the AMA had sunk in public esteem because of its opposition to a nationwide system of blood banks that Red Cross wanted to set up. Even conservative politicians will in the end follow the line of least resistance. The AMA was desperate.

In its desperation it undertook to raise a $3.5 million war chest and hired a firm of public-relations experts. It set up a new lobby in Washingtion whose function was only to lobby (public relations henceforth would be handled elsewhere). The hucksters studied the situation, and advised that the public had to be offered a positive-looking alternative to socialized medicine—namely, Blue Cross and Blue Shield.

As we all know, the Blue plans gave Congress the excuse it needed, and the Truman plan was defeated. But the defeat was more utter than the AMA could have hoped in its wildest dreams.

Part of the defeat was due to other AMA tactics. These included a program of letter-writing to Congressmen never surpassed before or since. They included massive direct advertising. They included political intervention, through the contribution of campaign funds to defeat Congressmen conspicuous for their belief in socialized medicine. They included public relations gimmicks, some of which I discussed in the previous chapter. They even included a four-color sixteen-page comic book, "The Sad Case of Waiting Room Willie."

But the main causes of the defeat were two. First, the fact that the Blue plans grew enormously and, for a while, on a superficial level did look as though they might really meet the medical crisis. Second, the fact that the period of McCarthyism and "massive retaliation" was not a period in which imaginative social thinking was warmly welcomed in the halls of government.

But at the end of the Fifties, lo, socialized medicine once more rose from its ashes and became a political issue.

The Forand Bill

In 1957 Representative Aimé Forand (Dem., R.I.) introduced a bill to increase Social Security taxes one-fourth of one per cent, so as to cover the cost of hospitalization and surgery for some 13,000,000 recipients of Social Security benefits. The bill attracted little attention outside the medical press, and never even got out of committee. But Mr. Forand reintroduced it in the next Congress and the AFL-CIO then made it the subject of a special crusade. By 1960 it had again failed of passage, but not before it had been endorsed in the 1960 Democratic platform and also taken up by some liberal Republicans.

By this time everybody of every political texture was giving lipservice to the thought that old people have a "special" problem of medical costs. (They don't, of course: They have everybody's problem, only more so.) Even the president of the AMA labelled the financing of medical care for the aged as "medicine's number one problem." (Note: It was "medicine's" problem, not the nation's!)

In the special session of Congress held in 1960 after the national party conventions, Democratic nominee Kennedy made a special effort to get the Forand bill passed, making substantial concessions along the way, such as increasing the age of first coverage to 68. The Republican-Dixiecrat alliance, in voting him down, used the excuse that President Eisenhower would've vetoed it anyway. Instead they passed a bill increasing the financial aid available to "paupers," those who take a means test and prove they're too poor to afford medical care. This aid becomes effective only as each state votes matching funds.

Of course, the people who need help to meet medical costs aren't at all the paupers, for whom charity care is already available, but people of low and middle income who don't want to become paupers. Nobody who wanted the Forand bill was remotely conciliated by the "substitute"; the Forand bill was an explosive issue in the 1960 elections.

Those who opposed the Forand bill said it was socialized medicine. Those who favored it said it was not socialized medicine. Actually, both were right.

The Forand proposal was very far indeed from the comprehensive program which our nation so urgently needs. It was a paltry thing compared even with the 1948 Truman plan. It provided coverage limited as to time, and therefore dodged the problem of people with chronic ailments—desperate to those faced with it, yet a trivial cost in terms of the national budget. It didn't provide for nonsurgical doctors' fees: Heart disease, for instance, is a major killer of old people, and the Forand bill would've paid the hospital bills of old people suffering from it; but it wouldn't have paid their doctor's bills unless they had heart surgery—which for elderly people is unlikely. There were other flaws.

But if the Forand bill was not socialized medicine, it was still an entering wedge, for it proposed to set up, within Social Security, administrative machinery capable of expansion into a genuine system of socialized medicine. Furthermore, it was a plan that included a whole segment of the population on a basis of need rather than of income level. Heretofore government-financed aid has been available only to special groups—to veterans and paupers and ambassadors and convicts and presidents. (President Eisenhower never had to pay a medical bill during most of his adult life. But he opposed, as a matter of firm principle, socialized medicine for ordinary people.)

The most interesting thing about the Forand bill is the deep responsive chord it struck among the public. Straw in the wind: The New York Times, in its issue of September 8, 1960, reported with a tone of surprise on a survey it conducted among "elderly voters" in St. Petersburg, Florida. *Without being asked,* a large number of the people queried said they'd like, as one of them put it, "to see the whole thing go a step further and go into socialized medicine." This was "one of the striking returns from the informal poll of scores of persons," observed the Times. "About one-third . . . volunteered their advocacy of a national medical plan. Many of them were well-to-do.

"One was Peter J. Boyle, 78, [who]

said he had helped gather 1,000 signatures last month for a petition to [his Congressman], demanding 'socialized medicine and hospitalization.' 'Ninety-five per cent of the people we approached were delighted to sign it,' Mr. Boyle said."

A number of old people were quoted as protesting the means test which they must take to be eligible for aid under the "substitute" bill Congress passed. A Mrs. May Webber asked, "If a person has enough pension to live on and maybe a small amount of savings, do they have to use that up before they get any help?" (The answer was yes.) "And if they do use it up what happens to them if they get well?" (What, indeed!) A Mrs. Ethel Cahill told the Times how small groups of single aged men or single aged women share lodgings to save for food and clothing in budgets that don't allow for sickness. "A neighbor said to me this morning, 'Ethel, please get me a bottle of insulin at the drug store, and I'll pay you when the check comes.' Of course, I won't take the money. But should that happen? There are hundreds, thousands like that here."

The Forand bill experience demonstrates, then, that after a decade of AMA brainwashing the public still wants socialized medicine. To those of us who believe in it and are also prepared to do something for our belief, this means it's still, or again, worth while to go out and work for it.

Piecemeal Gains

During all the many years when socialized medicine was again and again going down in defeat, at the same time there was steady extension of gradual government intervention into medical costs.

Bit-by-bit government medicine has already taken us further than most Americans realize. There've long been programs for merchant seamen, veterans, and so on. When you add the various local and national paupers' programs, and a miscellany of several dozen minor programs for this or that special group, it appears that about one-fourth the American people now can qualify for some form or degree (usually inadequate) of government-assisted medical care.

One hospital bed out of ten is owned by the Federal government. Six more out of ten are owned by state, county, or city governments.[40] Three-quarters of them are for mental illness, tuberculosis, or disabled veterans; that is, they're institutions for the care of longterm illnesses (the most expensive kind.) [41] The fact is that longterm hospital care has already been partly socialized.

Of the remaining 30 per cent of hospital beds a large portion are in "nonprofit" institutions; that is, they're helped by special tax write-offs. Moreover the Hill-Burton Act has involved the Federal government in construction of nonprofit hospitals: In the first ten years of that act it has helped pay for 135,000 new beds in hospitals and nursing homes, and 750 units for outpatient care.

Federal research monies help maintain hospitals and medical schools. Epidemiology is pretty throughly socialized under the Public Health Service. In addition to the Forand bill, Congress is now considering aid to the costs of medical education and grants for the building or expanding of medical schools.

Naturally all this put together doesn't begin to add up to socialized medicine. The situation is comparable to where we were on the eve of the Social Security Act. There were thousands of private annuity plans run by employers or by insurance companies; a number of states had laws approaching the idea of Social Security; there were many special Federal or Federally-assisted programs. Yet the day before Social Security was enacted we did *not* have Social Security, and the day after we *did.* Private and subsidiary plans were still important, and there was room for lots of improvement in the Social Security Act (there still is), but we now confronted the whole problem of retirement security on a new and higher plateau. So now with socialized medicine: The first and overwhelming problem is to establish the principle of public responsibility.

8: THE QUALITY OF MEDICAL CARE

"That any sane nation, having observed that you could provide for the supply of bread by giving bakers a pecuniary interest in baking for you, should go on to give a surgeon a pecuniary interest in cutting off your leg, is enough to make one despair. . . . And the more appalling the mutilation, the more the mutilator is paid. He who corrects the ingrowing toenail receives a few shillings; he who cuts your inside out receives hundreds of guineas."

— George Bernard Shaw

The UMW Fight

For the past decade the American scene has been enlivened by a running battle between the AMA and the United Mine Workers' Welfare Fund. In John L. Lewis, the AMA seems at last to have met its match.

In Kentucky the state medical society tried to get a bill passed that would have forced the UMW to pay any licensed doctor a miner went to. In Illinois the medical society formally condemned the UMW for interfering with "free choice"; in Pennsylvania for a brief time it was "unethical" for doctors to have anything to do with the union. In Trinidad, Colorado, when two new specialists moved to town in 1954 to treat patients under contract with the UMW, the county medical society refused to admit them to membership, and they were consequently excluded from Trinidad's one hospital. After four years of this they sued the medical society for "conspiracy in restraint of trade," asking $75,000 in punitive damages.[42]

Finally, at its 1959 convention, the AMA backed down. Its decision, that henceforth "free choice" included the right to choose freely among medical plans as well as among doctors, was in part a response (and a capitulation) to the UMW. This decision, however, has in practice done nothing to lessen actual AMA hostility to labor and cooperative plans.

When the UMW Welfare Fund first set up its program, all any mineworker had to do was see his own doctor and have the bill sent to the union. This soon proved utterly unworkable. First, because many doctors promptly jacked up their fees. Second, because it soon became clear that many doctors in mining towns were incompetent. (People there are poor; therefore so—relatively—are doctors; therefore these towns tend to attract second-raters.) We "have literally been forced,"[43] says a UMW spokesman, "to set up programs of physician selection."

The UMW has built a chain of modern hospitals in the mountains of Pennsylvania and West Virginia, has imported specialists, and has revolutionized health standards in mining towns all

[ERRATUM—On page 24, left-hand column, lines 17 ("over the nation . . .") to 25 ("The UMW . . .") are misplaced and belong at the very top of the column.]

that any program for financing medical care must also be tied to controls over the quality of care. It also demonstrates, again, that on this subject the AMA is touchier than on any other.

Salaried Practice

The battle over control of quality has mainly been fought by the cooperative medical plans. For decades doctors in these plans have been excluded from medical societies and hospitals, and have fought back with lawsuits.

The cooperative plans are those in which a group of consumers get together, raise money, build a hospital, and hire doctors on a *salaried* basis to give them comprehensive medical care for a flat over the nation. Thousands of crippled miners were capable of full or partial rehabilitation, but until the Welfare Fund came to their aid they had no chance to get the help they needed: This is the most spectacular change wrought by the UMW, but still is only one of many.

The UMW experience demonstrates monthly fee. There are variants on this theme: The pure medical co-op is a consumer-run democracy, but some very similar plans were set up not by patients, but by doctors. These aren't co-ops, but like the co-ops they involve salaried doctors offering comprehensive care for a flat fee. In some of them such as the Health Insurance Plan of Greater New York, many participating physicians work for the plan only part time and in their own private offices, where they also see private patients on a fee-for-service basis. The general term for all such plans (including the UMW plan and the co-ops) is "closed-panel" plans, which is a term coined by the AMA and means that doctors outside the panel of participating physicians get no chance to see participating patients.

But the important point about the UMW, cooperative, and other similar plans is not the fact singled out by the AMA, that they exclude some doctors. It's the more basic fact that the physicians are paid a yearly salary. These plans have abandoned the whole concept of fee-for-service-payment-when-you're-sick. And the significance is this: Whereas most doctors find it pays to have people sick, salaried doctors find it pays to have them healthy.

Under the fee-for-service system if a doctor's in doubt as to whether your tonsils should or shouldn't come out, his pocketbook urges him to decide to yank them. If he doesn't, he won't get paid. The salaried doctor, however, gets his money whether he takes your tonsils out or not; *his* pocketbook urges him to decide not to yank them unless it's really necessary.

In China, it's said, it was anciently the custom for people to pay doctors only so long as they were in good health, and to stop paying for as long as they were ill. This intelligent practice has in a sense been revived with the development of salaried practice. The salaried doctor puts in the least work for his money, and cuts down on his overhead, by keeping you healthy in the first place. Salaried practice therefore is intimately linked with the concept of preventive comprehensive medicine, and the cooperative plans all emphasize the importance of patients having annual checkups. Fee-for-service practice, on the other hand, is logically linked with the concept of remedial medicine; it pays the ordinary doctor to wait for you to get sick before he sees you.

It will of course be a long time before annual checkups on a mass basis can be conducted at a Mayo-clinic level (several days of tests); but a number of standard screening tests *can* be performed on a mass basis and constitute a very big step toward providing everybody with higher quality care. This kind of preventive care is a primary goal for socialized medicine. It therefore follows that (1) for the present, those who support socialized medicine also support salaried practice and cooperative medicine; and (2) for the future, we must strive for a system whose administrative pattern provides incentives for doctors to give care that's preventive in its orientation.

The British Health Service

The British system of socialized medicine teaches us further lessons about quality control, and for that reason

WHO KILLED DR. GARABEDIAN?

In the early summer of 1960 Dr. Joseph Garabedian, a 41-year-old obstetrician of Staten Isand, New York City, collapsed and died from overwork. The technical cause of death was a bleeding ulcer; the fact behind it was that Dr. Grabedian was the only obstetrician serving 24,000 Staten Island members of the Health Insurance Plan of Greater New York.

Why was he the only obstetrician? Because he was the only HIP doctor granted hospital privileges on Staten Island. The AMA officially no longer regards participation in a "closed-panel" plan as "unethical" (and at any rate, HIP is about the least radical closed-panel plan in the entire nation); nonetheless, other HIP doctors were consistently refused the right to admit their patients to local hospitals.

Dr. Garabedian's death caused a newspaper hullabaloo and led to an inquiry by a New York state legislative committee. At this inquiry Dr. Herbert Berger of Staten Island's medical society testified, in effect, that Dr. Garabedian's death should be regarded as suicide. "He could have resigned" from HIP, Dr. Berger pointed out.

Why are HIP doctors excluded from hospitals? he was asked. It's "a personal and social matter, not a medical one," Dr. Berger deposed. "I have no question about the medical competency of these doctors."

"It is a medical problem," objected state senator Metcalf.

"No sir, it is not, not in my eyes," replied Dr. Berger.

What were Dr. Berger's "personal and social" objections to HIP doctors? The only points he could think of was that they're "disputatious" and "transients." This naturally subjects them to "social nonacceptance by their colleagues," he explained. Then, in a brilliant exhibition of circular argument, Dr. Berger continued:

"No one denies that this can be a devastating experience. But they have made the mistake of isolating themselves from the rest of the profession. This can be readily rectified by resigning. Many of them do just this. More than half of the [HIP] physicians who come to this community have done so." Others, he added, move away.

Anyway, said Dr. Berger, how could you be sure Dr. Garabedian really died from overwork? Carrying AMA fatuity to new pinnacles of glory, Dr. Berger gravely pointed out that after all, Dr. Garabedian was a "Turk" (since when are Armenians "Turks"?) and that the government had recently collapsed in Turkey. Maybe, he suggested, that's what was worrying Dr. Garabedian.

I've held off discussing it until I reached this point. But before examining it for the lessons it can teach us, let's take a more general look at it. What was the initial impact of the British Health Service, and what are its effects now after more than a decade?

To grasp what socialized medicine has come to mean in Britain, try to picture what it would be like if we had no public schools and few private ones; if we had to find and pay private tutors to educate our children. This is, of course, almost unimaginable. Equally, our present system of medical care is unimaginable to young people in Great Britain. They find it hard to realize how British medicine worked before socialized medicine, and imposible to understand why.

The British Health Service is still costing up to 15 per cent of each person's income tax, or $44 per capita per year. This is a lot of money. Yet opposition to the Health Service is virtually nonexistent. Not only does the Conservative Party not oppose socialized medicine, it tries to grab credit for it. A British politician would no more oppose the Health Service than an American politician would oppose public schools.

Ninety-seven per cent of the populace is enrolled in the Health Service, although nobody is under any obligation to join it.

When the Health Service was first proposed, only 17 per cent of British doctors favored it. At the time it began operating, British doctors were about equally divided on it. Today 87 per cent of them wholeheartedly approve of it. Eleven per cent are indifferent, and only 2 per cent still hold out against it. When British doctors are asked about it they stress the professional and human satisfaction they get, in knowing they're really succeeding in keeping people healthy. They tell you how wonderful it is to be free to prescribe for a patient any drug or procedure he needs, without having to wonder if he can afford it, or look for substitutes if he can't.[44]

The AMA tells American doctors that socialized medicine means coercion by the government, lower incomes, and reams of burdensome paperwork and "red tape." In fact, no British doctor is obliged to work in the Health Service and some still don't. In fact, most British doctors now make *more* money than formerly: Even allowing for devaluation of the pound, the typical British general practitioner has an average income of around $7,000 a year, compared to less than $4,000 before the war.[32] In fact, British doctors have *less* paperwork than American doctors, since they have only one standard set of forms to fill out, whereas American doctors must cope with a thousand different forms for a thousand different insurance and government schemes.

Between 1947, the last year before socialized medicine, and 1957, infant mortality per thousand live births went down 42.5 per cent. In the United States, during the same period infant mortality went down only 19 per cent. In 1947 the British rate was higher than the American rate; now it's lower.[45] The rate is also lower in Sweden and New Zealand, the other two nations which, with Britain, enjoy the most comprehensive programs of socialized medicine.

Ever since socialized medicine began, periodically AMA politicians have gone on junkets to Britain, dug up a few eccentrics who dislike the Health Service, and come back to tell American doctors how perfectly awful the whole system is. Now the British Medical Association has finally had enough, and recently it has issued several public blasts at the AMA declaring that AMA

reports are completely distorted and false. Yet fifteen years ago the BMA and the AMA saw wholly eye-to-eye on socialized medicine.

What We Can Learn

Naturally the British Health Service is not without its flaws. A good summation was given by a Tory member of Parliament, who remarked recently that the British have "a second-class medical system. But," this man went on, "we used to have a fourth-class system—and we're getting better all the time."

The British have been broke in much of the postwar period and they never put into the Health Service the money they'd originally planned for it. They intended to build hospitals and clinics all over the country; this program is hardly yet begun. There are other flaws.

But most of them can be traced back to the bad old days. An American physician, Dr. George A. Silver (chief of the Division of Social Medicine at Montefiore Hospital, in New York City) has put it like this: "The defect of Britain's National Health Service," he says, "is not in too much socialism, but too little."

Writing in The Nation,[46] Dr. Silver continues: "The coalition government that inaugurated the new service was very careful not to meddle with the status quo of medical practice. Succeeding governments have been equally careful to retain the outworn traditional features.

"The 20th Century requires a medical system that will allow the full benefit of accumulated and changing medical knowledge to be applied to the patient. While the family doctor is still necessary, the general practitioner is outdated. Specialized knowledge shifts and expands so rapidly that only highly-trained specialists can apply it. These specialists must have an organization for communicating with each other, enabling them to economize on time and effort. This is group practice.

"And group practice needs a center—a physical home. Further, group practice must be intimately associated with modern hospitals."

The British had blueprinted elaborate plans for setting up health centers in every village and neighborhood, where the local doctors would all have their offices and work closely with one another and with specialists. These were not built, and consequently the British family doctor remains isolated in his office. Patients enroll with a general practitioner, and see specialists only on his referral. While there has been some development of group practice, the general effect has been to freeze the pattern of British medical practice at the point to which it had evolved in 1947.

Yet in fact the pattern of medical practice is changing rapidly. In America, even without the incentive socialized medicine could apply, there has still been a strong trend toward joint or group practice. By 1956 only 56 per cent of American doctors were still in solo practice. The remaining 44 per cent were teamed up in various combinations.[47] And American medicine becomes daily more and more a team job.

Again, the British system focussed on the general practitioner precisely at the moment of history when he was starting to disappear. In 1950, the AMA Directory for that year shows, 48 per cent of American doctors in practice were GPs, and 37 per cent were specialists. (The remaining 15 per cent were "partial specialists.") By 1958, only 39 per cent were GPs while 47 per cent were specialists.

The British Labor Party is pledged to spend fifty million pounds a year for

many years on the building of new hospitals. It plans to give more emphasis to group practice, and to push for more occupational health services (medical units in industry). By contrast, the Tories seem happy with the Health Service the way it is; their only change has been to add charges for a variety of minor services, and institute a number of petty bureaucratic harassments in connection with those charges. (Harassments which the AMA likes to point to as an argument *against* socialized medicine, but which actually show that British medicine isn't socialized enough.) In sum, the flaws in the British system do indeed show the need for more socialism, and in time they'll be corrected by the socialists of the Labor Party.

The lesson for Americans? To quote Dr. Silver again, it's this: "A plan for removing the economic barriers to 20th-Century medical care has to be coupled with a program for [modernizing] medical practice. . . . It has to . . . provide a framework for group practice . . . and offer modern, easily-available facilities and equipment."

Specialism and Group Practice

One of medicine's problems, I pointed out earlier, is that it's a service industry and can't economize by adopting mass-production methods. Yet to a limited degree it can, by the use of group practice and specialization. Clinics consisting of a number of specialists—or, indeed, clinics consisting of a number of general practitioners—can not only give consistently better care than any other form of medical practice; they can also see more patients for less money. Most of the "closed-panel" plans offer clinic-oriented care; this is why they're such fierce competition for privately-practicing physicians, and why therefore they're so bitterly fought by the AMA.

In such a clinic the doctors are housed in nextdoor offices where they can readily consult with one another. Since there are fifty-one official specialties and subspecialties, such consultation is vitally important. They share laboratories, a business office and filing system, nurses and technicians. They also share each other's services; for instance, a radiologist may be on the premises to read x-rays for all his colleagues.

If you're a new patient in such a clinic you're first seen by an admitting physician, usually a specialist in internal medicne. If you're an old patient you go regularly to the admitting physician of your choice, and he's your "family physician." If your problem is minor and evident he prescribes for you on the spot. Otherwise he routes you to the appropriate specialist, or sends you for laboratory tests and tells you when to return. Possibly several doctors will see you all at the same place and discuss your case with one another. For the doctor this is the most stimulating of all possible environments in which to practice; for the patient, if offers the highest possible quality of care. Group practice makes available to non-hospitalized patients the kinds of elaborate and expensive equipment, and the wider spectrum of medical talent, usually available only in hospitals.

Even when nonspecialists go into group practice, the quality of care is upped. Take any small town with, say, four competent GPs, and consider just what happens when all four of them abandon their separate offices and move into a central medical building with joint facilities. An immediae result is that they can offer their services cheaper, because overhead is reduced. A second result is that their competence goes up, for now they're all looking over each other's shoulders, and shabby workmanship is much harder to get away with. If they go a step further and set up joint billing—a step toward salaried practice—with equal division of all the money that patients pay in, the results are even more startling—you begin to get automatic partial specialization. Doctor A who's interested in obstetrics sees most of the expectant mothers. Doctor B who's fascinated by heart disease sends his mothers to Doctor A, and Doctor A tells his heart patients to go across the hall and see Doctor B. And so on.

The doctors also find they've enjoying a better way of life—evenings and weekends off while they take turns being on call; sabbatical leaves so they can go take refresher courses without losing their practices. The patients get rested rather than exhausted physicians, who are constantly improving themselves professionally.

"There is no question that group practice can provide better medicine." This quote doesn't come from a dissenting member of a cooperative medical plan. It comes from Dr. Gunnar Gunderson, 1959 president of the AMA.

The obvious conclusion from all this is that in any attempt to rationalize the distribution of medical services, high priority must go to the building of clinics. Even with fee-for-service medical care, a town or neighborhood that builds a medical center—with, perhaps, laboratory facilities, extra space for visiting specialists, an emergency ward, and a nursing-home annex—has already taken a major step toward better medical care, and one that's appropriate to the most ideal form of socialized medicine.

To recapitulate: In thinking about socialized medicine, and in our attitude toward proposals for piecemeal government medicine, we must emphasize (1) cooperative (consumer-run) medicine, (2) salaried practice, (3) group practice, and (4) the building of local medical centers. All these relate intimately to

SAVING LIVES

Scores of studies prove again and again the medical superiority of salaried group practice. To take one example: In New York City, over a three-year period, stillbirths and deaths in early infancy were found to occur at a general rate of 35.4 per thousand deliveries. When the mothers were cared for by private physicians, the rate went down to 27.9 per thousand. And when mothers were attended by physicians associated with the Health Insurance Plan of Greater New York, the rate went down to 23.1 per thousand.[48]

SAVING COSTS

Group clinics not only offer better care, they offer it cheaper. Dr. Russel Lee, who heads the eighty-physician Palo Alto Clinic in Palo Alto, California, says he has learned "from experience that a group can profitably give complete medical service at $5 per person per month."

The Palo Alto Clinic, he says, "has such a deal with the Masons. We take care of all their old people at that price. Old people, remember, aren't supposed to be insurable. And these Masons are from 65 to 105 years old. . . . One year we made $234 on the deal. We kept a careful check. At $5 a month we took in $234 more from them than we would have earned on a straight fee-for-service basis. If it can be done for old folks, it can be done for anybody."[49]

the quality of medical care as well as to the problem of distributing it fairly and economically. And meanwhile we must try to get our own states, counties, towns, co-ops, or unions to make a start. Building community clinics is one way to begin, just as starting or improving a co-op plan is another.

9: AN AMERICAN APPROACH

When we attain a complete system of socialized medicine in this nation, how should it be organized?

The objectives are these: It must distribute the best possible care in the fairest possible manner to the greatest number of people as economically as possible. It must be a system whose built-in natural tendency will favor these goals. It must be a flexible system, corresponding to the vast differences between local traditions and conditions across the country, and able to adjust to changing medical technology. It must be a system appropriate to the traditions of American democracy. It must avoid the evils of bureaucratization which already, especially in hospitals, dehumanize our medical services.

A system of socialized medicine will need to be organized on three levels, roughly corresponding to the division between state, local, and Federal governments. On the broadest or Federal level we'll need two things: An agency for maintaining standards, and arrangements for footing the bill. On the narrowest or local level we'll need to concern ourselves with the distribution of medical services, the way doctors set up practice and get paid. In between, on a state or regional level, we'll need arrangements for planning, to make sure there are enough hospitals, medical schools, specialists, and so on.

Medical Services and the School System

The school system springs to mind as an example of a socialized service offered on a village or neighborhood level and subject to local control. It has many deficiencies as a model; it also has many advantages.

For one thing, it shows a way in which a socialized service can be evolved into locally. Not too long ago there weren't any public schools in the United States. But there were private schools, many of which later became part of the public-school system. Some cities and states began to have public schools before others did. Of course, the school system hasn't been subjected to Federal rationalization, which is a must for socialized medicine; but it still shows how a start can be made right away.

The school system exists side-by-side with private schools and private tutoring. Likewise there's no reason why socialized medicine shouldn't exist side-by-side with private clinics and private practice.

Teachers are free to find a school to work in that suits their interests, or to work for private schools, or as tutors. Likewise doctors could be free to choose among a variety of local systems. Or they could join private clinics or go into private practice.

Schools are administered by local school boards, or by city or county governments. They raise part of their money by local taxation, and get the rest from the state. The state government's role is limited to the licensing of teachers and the maintenance of minimum standards.

Likewise socialized medicine could be administered by local boards, selected in any one of a number of ways. The Federal government would have to supply the bulk of the money and set standards, but localities could be left free to raise additional funds and spend them as they chose. Doctors are already licensed by state governments.

School systems are free to spend their money as they wish, so long as they meet standards. They can build new buildings, offer special courses ranging from agriculture to zither-playing, set what salaries they please, hire teachers by the term or by the day or pay them per pupil per class.

Likewise with socialized medicine: The Federal government should supply the money, virtually all of it; but localities should be free not only to raise additional sums, but to make whatever arrangements please them about their methods of reimbursing doctors and providing services to the public.

What about the things that are wrong with the school system? As we all know, school standards vary incredibly from place to place. Many schools are officially segregated as to race; many more are de facto segregated as to race or income group. Teachers are woefully underpaid almost everywhere. The school system is class-ridden, in that wealthy communities offer the best schools, working-class districts the worst. The citizens who exercise direct control over the schools must choose between their wishes as parents to give their children the best education possible, and their wishes as taxpayers to pay as few taxes as possible; too often the pocketbook wins.

To avoid such inequities, we must insist on (1) high Federal standards rigorously and equally enforced, and (2) payment through the Federal government of the great bulk of the costs.

As we work to involve our communities in medical costs, and to increase the scope of the cooperative plans, we must simultaneously work to involve the Federal government in programs that will mean its sharing in the costs of local and cooperative plans. We must emphasize the importance of strict supervision of standards by the Federal government in any proposed program Federal monies are to pay for.

Localities shall ultimately be left free to do only three things: (1) raise additional funds for extra services not nationally required; (2) determine together with their doctors how doctors shall be compensated; (3) arrange for the actual administration of medical services on a local level. This prospect obviously means keeping the fee-for-service system in some areas perhaps for some time to come. But it may safely be assumed that in time this system will pass away into limbo. First, because it will no longer offer built-in economic incentives to the doctors. Second, because salaried preventive group practice is less expensive, provides better care, and is more appropriate to modern medical technology. Third, under local pressure: Just as today parents choose to live in one town rather than another because of the difference in school systems, so towns will also compete to offer better medical services. Fourth, under Federal pressure: by precept, by the building of medical conters, by tax incentives for doctors who work in salaried group practice.

The people most concerned with the public schools, parents and teachers, are organized into Parent-Teacher Associations through which they wield an enormous influence on the nation's education. A similar development should be planned in connection with socialized medicine. The seeds of this are found right now in the consumer associations that run the co-op plans, and will grow in interesting ways where such co-ops take on certain public functions.

Federal Participation

This discussion of the school-system pattern reveals a number of ways in which the Federal government must intervene on behalf of fairness. To summarize—

It must provide the overwhelming bulk of the money needed. It must take specific steps to see that minimal standards are fully met in all communities rich or poor; and the only method of guaranteeing this is to arrange for Federal payment of all services required in a Federal code of standards.

It must protect both doctors and patients by a code setting forth their rights. It must protect doctors, nurses, technicians, and hospital workers by minimum wage laws and other guarantees such as the right to strike.

It must provide tax incentives for salaried group practice, and likewise to encourage a proper distribution of doctors—GPs in isolated communities, specialists in areas deficient in their specialty.

The costs of socalized medicine could presumably be met entirely through yearly appropriations by Congress. This is probably the way to pay for capital expenditures, for new hospitals and medical schools. But for the regular day-to-day cost of giving people the medical care they need, another method of financing should be found, one less capricious, less subject to the winds of political chance.

The obvious model here is the Social Security system, which collects its own taxes directly and operates at several removes from the politicians. Socialized medicine should be paid for in the same way, by contributions from employers and employees, either as a separate program or as part of Social Security. If it operates as part of Social Security some provision should be made for the millions still not covered by that program. The Social Security administrative board should make payments directly to local medical districts, based on the population in each district with adjustments for areas where, for instance, there's a preponderance of old people or other factors that would alter normal demand.

Standards should be supervised by a special board operating under a detailed code passed by Congress. This code should specify, for instance, which services a hospital must offer to qualify for Federal payments. The board should function under the "reserved powers" concept—thus, where an area has insufficient or low-quality medical care, if progress is not rapidly made under local auspices the board should be required to step in and make adjustments; but normally, communities should be left free to make any arrangements they please. This board would have limited judicial powers, to hear complaints by medical groups and communities, in which it would be subject to review by the courts. It should consist of commissioners appointed by the President, at least one of whom should be a physician.

Regional Planning

There remain an assortment of administrative problems that can best be dealt with on a state or regional basis.

These problems include the matter of distribution of doctors, and beyond that, the matter of providing enough doctors in the first place. They include planning for the building of new hospitals and medical schools. They include the administration of hospitals. They include the parcelling out of research work.

American medicine is already organized on a regional basis. For instance, all of northern New England is medically satellite to Boston. A patient who's seriously ill is removed from his community clinic to a hospital; if the case is especially difficult he's removed to one of the teaching hospitals in Boston. Boston specialists travel to Maine and Vermont to visit patients who've been referred to them. If there's a medical blunder the Harvard Department of Legal Medicine is likely to be consulted. And so on. Similarly throughout the country teaching hospitals and medical schools form the nucleus of medical regions which may include several states or maybe only part of one.

This is the obvious level at which overall planning should be administered.

Medical regions should be administratively rationalized under the control of boards elected on the TVA principle: with board members appointed by both state and Federal governments, with other members perhaps elected directly or perhaps chosen by community medical districts. They should have complete charge of hospitals and medical schools, including medical-school scholarships. They should get a certain share of tax monies raised for socialized medicine, and should be free to ask state and Federal governments for special appropriations for capital expenditures; to sell bonds and contract debts; to institute public appeals. They should be subject to a general Federal code of standards.

The regional administration would deal directly with local medical districts in building local medical centers and arranging for liaison between those clinics and hospitals.

. . . . .

What is here offered is an administrative blueprint for socialized medicine. Behind it is the assumption that socialized medicine is achievable in the near future, and that therefore the time has arrived when blueprints are necessary.

10: WHAT TO DO

If socialized medicine is achieved in the near future it will be because people who want it go out and work for it. I have suggested a number of ways in which we can work for socialized medicine. Let's review them—

1. We can use every possible opportunity to advocate socialized medicine, in all the usual ways: by writing Congressmen and editors, by trying to get candidates for public office to commit themselves, by distributing this pamphlet and other literature to our friends, by organizing public meetings and debates.

2. We can work for political realignment, for a division of political forces such that we can cast a meaningful vote for socialized medicine. In this struggle we are necessarily allied with people who want other social reforms, and who are also stymied by the Republican-Dixiecrat alliance that controls Congress. Most especially we are allied with those who are fighting for civil rights for Negroes.

Not merely because Negroes, as an underprivileged group, are especially in need of socialized medicine; but also because civil rights is the issue that most deeply divides the Democratic Party, and holds the greatest political promise of isolating the reactionary Southern Democrats—the first and most crucial step toward realignment. It's a plain fact that whenever we do anything to advance the cause of civil rights—when we join a picket line, give money to the NAACP, protest sit-in arrests—we're not only helping to advance civil rights, we're also advancing socialized medicine, fair labor laws, a less belligerent foreign policy, and a host of other causes which now are blocked by the undemocratic

character of political parties in America.

3. We can do everything possible to encourage Federal intervention in the financing of medical costs on a bit-by-bit basis. And we can work to direct such intervention so that if it isn't socialized medicine proper, at least it paves the way for socialized medicine. To this end we must give high priority to attempts to amend legislative proposals in ways that'll involve the government in medical *standards,* and in a way favorable to cooperative and group medicine.

4. We can enroll in local cooperative and "closed-panel" plans where they're available, and work to make them better. We can work for local public subsidy of existing co-ops, or for their involvement in local public medical programs, to convert them gradually into public institutions. We can help found new co-ops, either in our communities or through our unions.

5. We can work on a direct political level for as much as we can get in the way of local socialized medicine.

6. We can join or give money to organizations working for socialized medicine. This means—

If you're a trade unionist: Join COPE (the AFL-CIO's Committee on Political Education) and help labor work for political realignment, for cooperative medicine, for socialized medicine. Circulate this pamphlet among COPE members. Help make *your* COPE active on a ward and precinct level.

If you're a physician: The most important thing you can do is *visit* your Congressman, and help counteract the AMA's visiting and letter-writing campaign against the Forand bill, etc. If you want to get involved in salaried group practice, write to the Group Health Association of America, 343 South Dearborn Street, Chicago 4, Illinois.

Support cooperatives: Be active in your local consumers' or producers' cooperative; try to get the local co-op movement to initiate a medical plan.

And of course, whatever else you do or don't do, if you really want to fight for socialized medicine you'll join the Socialist Party-Social Democratic Federation. For sixty years no organization has worked harder or more intelligently for socialized medicine. Contributions may be sent to SP-SDF, 303 Fourth Avenue, New York 10, N. Y.; they should be earmarked for the Committee on Medical Economics.

11: BEYOND SOCIALIZED MEDICINE

The best of liberal reforms too often are shortsighted; they tinker with a society whose sickness is basic, and by which they are quickly reinfected. This is especially true in regard to medical services. For it's as plain as a pikestaff that given the most perfect form of socialized medicine, our present society will still afflict its citizens with a multitude of ailments which are socially preventable.

To take only the most obvious example, consider how much illness is caused by slum housing and malnutrition. It makes good sense to set up a system that'll cure all such illnesses without regard to a patient's income. It makes better sense to keep illness from happening in the first place by abolishing slums, by assuring that all children are well-fed and grow up strong and healthy.

The high incidence of heart disease, ulcers, neurosis and insanity, all are caused in large part by the tensions of the world we live in. Unhappy people are prone to be sick people. People who are dissatisfied or embittered, who are

consumed by anxiety or ambition, people who've forgotten how to love one another—they fill our hospitals and mental homes. Unnecessarily.

We do not need to maintain a social order in which competition is more important than cooperation, in which economic and social distinctions matter more than friendship and trust. It's in our power to uproot the social institutions that nurture this atmosphere, and replace them with something new and gentler.

There are many Americans who maintain that we already have a classless society. All such should read "Social Class and Mental Illness,"[51] a report on a survey conducted several years ago in New Haven, Connecticut. The authors, August B. Hollingshead and Frederick C. Redlich, divided the New Haven population into five classes, according not only to income, but also to criteria of residence, occupation, and education. Their findings were shocking, and perhaps most shocking was the discovery that even when free treatment was given, the best service went to the highest class.

In private mental hospitals, 57 per cent of Class I patients (the highest category) got their bills reduced, and only 7 per cent of Class IV patients. Furthermore, for Class I patients the reductions began at an earlier date, and so on down to Class IV. The payment in dollars and cents for the average Class I patient was $24.76 per day; for Class IV patients it was $31.11.

In clinics built especially for the poor, where everyone pays the same nominal fee, patients in the highest class were treated by fully-trained staff psychiatrists, Class V patients by social workers or undergraduate medical students. None of the upper-class patients were given shock treatment. Seventy-one per cent of the Class II patients got analytic psychotherapy, compared with only 6 per cent of Class V. But 31.2 per cent of Class V patients were given sedation

or shock therapy—the quick, cheap, dangerous form of mental treatment. These clinics spent an average of $390 on each Class II patient, and only $48 on each Class V patient.

What all this means in short is that lower-class patients get the poorest medical care even when it's free; and when it's not free they have to pay more for it.

By the necessities of their training, doctors are men of relatively high education and cultural attainment. In the context of the social values that now rule our society, they identify themselves with others who possess the same advantages, and automatically give them preference. Those patients who are uneducated, ill-favored, inarticulate, those who work at lowly jobs, those who belong to the great army of American citizens who've come to expect to be pushed around—all these are liable to be short-changed at free medical clinics. There's every reason to suppose this would still be so if medical care became universally free tomorrow.

I believe profoundly that socialized medicine, in the deepest sense of the term, will come to pass only when we rebuild our world in very basic ways. Ours is a society in which men are regarded not as ends in themselves but as things, to be manipulated and procced for the profit of other men, and to the debasement of all men. What's needed is a society in which man is himself the highest value, and human hopes and dreams are seen as the most infinitely precious thing there is.

Socialized medicine is one of the many reforms which, cumulatively, help to redress social imbalances and create a more perfect democracy. But as an ideal it does not and cannot exist in isolation from other social ideals. We can and should enact laws for a fairer disrtibution of medical services and costs. But when we've done so, we'll have won no more than one battle in a continuing war for social justice.

FOOTNOTES

(NYT is the New York Times; ME is the magazine Medical Economics.)

1. derived from figures ME Apr. 28 '58 p. 72.
2. ME Oct. '56 p. 202.
3. ME Apr. 28 '58 p. 48.
4. NYT Sept. 21 '59.
5. Frank Groner of the American Hospital Association, statement prepared for U.S. House of Representatives Ways and Means Committee, hearings on Federal Unemployment Tax Act, Apr. 10 '59. (mimeo) p. 4 .
6. Donald B. Straus, *Can We Afford to Be Healthy?* Harpers, July '60, p. 38.
7. National Health Education Committee.
8. Straus, *op. cit.*
9. New York state health department as cited NYT May 10 '59; see also *Progressive* Sept. '58.
10. *Labor,* Aug. 23 '60.
11. Estimate by Social Security.
12. ME Nov. '57 p. 394.
13. ME Apr. 28 '58 p. 56.
14. *ibid.;* ME Apr. 14 '58 p. 45.
15. ME May '57 p. 350.
16. ME Apr. 28 '58 p. 42.
17. ME Mar. 17 '58 p. 90 *et seq.*
18. ME Nov. '57 p. 173 *et seq.*
19. ME Jan. 57 p. 17.
20. See any good history of medicine. For readability I recommend Jürgen Thorwald *The Century of the Surgeon,* Pantheon, 1956.
21. Odin W. Anderson, *Family Medical Costs and Voluntary Insurance: A Nationwide Survey,* McGraw-Hill, 1956, p. xiii.
22. *Ibid.,* Table A-16, p. 114.
23. U.S. Dept. of Health, Education, and Welfare, Public Health Service, National Office of Vital Statistics, *Vital Statistics—Special Reports; National Summaries,* Vol. 50, No. 14, Aug. 31 '59 p. 339.
24. *ibid.,* Vol. 43, No. 2, Apr. 4 '56 p. 23.
25. ME Sept. '57 p. 24.
26. ME Dec. '57 p. 18 *et seq.*
27. ME Jan. 6 '58 p. 48.
28. Richard Carter, *The Doctor Business,* Doubleday, 1958, pp. 89–96; see Chapter 5 for a complete account.
29. ME Jan. 20 '58 p. 36.
30. *Hospitals,* Journal of the American Hospital Association, Guide Issue, Aug. 1 '59 p. 284. Between 1948 and 1958 beds per 1,000 population declined from 9.7 to 9.1 per cent, and utilization rose from 115 admissions per 1,000 population to 137. Against this, the average hospital stay went down from 11.1 days to 9.6 days. But this last factor differs from the others in that it has a visible limit.
31. British Information Service, *The First Year of the National Health Service,* ID 961, Jan. '50 p. 3.
32. Don Cook, *Socialized Medicine, Ten Years Old,* Harpers, May '59 p. 34.
33. ME Quadrennial Poll, 1955: Oct. '56 p. 110.
34. NYT Aug. 28 '60; ME June 20 '60 p. 1.
35. NYT June 19 '60.
36. *Labor* Nov. 14 '59.
37. ME Aug. 4 '58 p. 19, p. 96; Oct. 13 '58 p. 91.
38. NYT Nov. 28 '60 .
39. For a fuller account of the AMA's political history, see Carter *op. cit.,* especially Chapter 10.
40. *Trends in the Supply and Demand of Medical Care,* Study Paper No. 5 for the Joint Economic Committee of Congress, U. S. Govt, Printing Office, Nov. 10 '59, p. 74.
41. *HEW Indicators,* Aug. '58 p. 19.
42. ME Feb. 3 '58 p. 44.
43. ME Dec. 22 '58 p. 33.
44. Cook, *op. cit.*
45. Compiled from government statistics of both nations.
46. Mar. 8 '58 pp. 203 *et seq.*
47. AMA *Directory* 1956.
48. Herbert Yahraes, *Making Medical Care Better,* Public Affairs Pamphlet No. 283, 1959, Public Affairs Committee Inc.
49. ME Nov. '57 p. 141.
50. ME May '57 p. 340.
51. John Wiley & Sons, 1958.

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