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Down at the Hospital

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DOWN AT THE HOSPITAL

by

Glenn E. Dickey

A thesis submitted in partial fulfillment
of the requirements for graduation

in

HONORS

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Glenn E. Dickey

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INTRODUCTION

Down at the hospital the other day the ambulance brought us an old German lady who had fallen down on Main Street. We admitted her in east wing and found no bodily damage, but did discover that she was thoroughly drunk. We removed her warmed-over cabbage tennis shoes and were in the process of replacing her Salvation Army discount dress with a hospital gown when three or four bags of Hershey's chocolate kisses fell out from some hidden foyer of her person. All the while she was yelling about her husband's federal pension and how her bishop and the police department would protect her from us. Last night she escaped from the hospital, and I, being the orderly on duty, had to hyperambulate down the street to capture her and return her to east wing, using force if necessary. It was. A half-hour later back in room 6, I was gratified to see 5 cc's of dilantin enter her left buttock via hypodermic needle because I knew that she would be as happy in dreamland as I was to see her transported there.

We enjoy a variety of patients down at the hospital, and there are a few varieties we don't enjoy. Mr. Clark in room 12 on third floor is an ailment who has blessed us with his continual presence ever since his hip operation. He practices the art of falling off his commode and re-dislocating the femur, returning to us the day after he is released. Mr. Moser in east wing room 11 sang birthday songs all the way up to surgery on the day of his operation, and was looking for the party when the anesthesiologist gassed him with nitrous oxide. Mr. Bills in east wing room 18 shakes the siderails all night long and pulls out his catheter every morning. Mrs. Miller on surgery floor room 21A could easily

outweigh middle linebacker Dick Butkus of the Chicago Bears and screams obscenities whenever the nursing staff uses the mechanical lift to remove her from bed rather than their latissimus dorsi muscles.

We are endowed with all sorts of patients. Rich patients bring four or five suitcases and never fail to pack their best jewelry and brand-new Fruit-of-the-Loom underwear. They take the \$56 rooms having one bed, wall-to-wall carpet, and the scenic views. Middle-class patients carry one suitcase and occupy the two-bed rooms. The people who fill the three-bed wards bring only their kin and family pet. One day a room will have a colostomy that constantly needs his bags changed, the next day a total hip that must have his traction poles tightened, and the next, a doting cysto who forgets to ask for a bedpan when she goes in bed. Every room is endowed with special patients, each with their own particular concerns and problems.

Long summer nights on the graveyard shift at the hospital leave many pensive hours for the interplay of ideas, and I often find myself slipping into moments of silent soliloquy, reasoning and wrestling with the onflow of feelings my work summons. On this particular night, I was making my usual way down the darkened hallways, working from room to room and shining my flashlight at IV bottles, when it gradually began to seem as though each room and bed possessed its own malaise that pierced and pervaded my thoughts. Each sleeping face began to plead with me through the silence: "I am an individual. I am more than just another body in another bed. I am more than just blood and guts. Don't turn me into a number on a door or an EKG line on a graph!"

I remember stopping and staring blankly down the dim corridor

toward the large elevator doors. Something very strange happens, I thought, when we take patients up to surgery through those doors. After checking to be sure that the patient is devoid of all jewelry, dentures, eyeglasses, underwear, hairpins, wigs, contact lenses, and other detachables, we deliver them to O.R. as simply a human body in a hospital gown. They will lose any aura of wealth, senility, or handsomeness. When anesthetized they will become only a mass of flesh and bone, each operating table occupant the same as any other. The rich people bleed like the poor ones; the educated businessman no different from the neighborhood garbage collector. And when the patients are brought into the recovery room, the handsome people will hurt just as much, need just as much demerol, and inhale just as many liters of oxygen per minute as the ugly ones. Only when the patients recuperate and return to their normal positions are they transformed from muscle and epithelial tissue into human characters.

After checking the last few rooms in the corridor, I stepped quietly down the east staircase. Isn't it a paradox, I thought, that medicine, the most humane and sensitive of all sciences, is the one most capable of dehumanizing the individual and stripping him or her down into nothing more than variegated protoplasm? I left the staircase and rounded the corner toward the east wing south hall and was about to pass the conference room, but decided to turn away from my normal course and look inside.

My intrusion exposed a long, wood-grained table glistening under the light from the corridor. Fifteen executive Naugahide chairs rested motionless around its sides, all randomly posed as though their suspension of activity would be but a moment. A piece of chalk

rested silently under a half-erased blackboard. Only a few scribbles remained, challenging the imagination to fill out a partially told story.

I quietly stepped in and gently sank into the large chair at the head of the table, setting my hands decisively on its padded arms. My eyes scanned the empty seats arrayed in front of me, and in my fancy I became the hospital chief of staff, perhaps even the president of the AMA itself. I was in command, and from my responsible position I could control the entire health care world. My eyes passed majestically around the room and happened to encounter the two words, "socialized medicine," scrawled in the upper left corner of the chalkboard.

Suddenly every light in the hospital was on. The room was packed with men in suits and ties, some filling the chairs and others standing around the sides. The doors were closed, the room was stuffy, and I knew there were newspaper reporters standing outside in the hallway waiting for a decision. I was still in the Master Chair, and I could tell this council was discussing something extremely important. A short man with a receding hairline and a small black goatee was standing by the chalkboard talking.

"All people are alike when it comes down to the bare essentials on the surgery table," he said. "All deserve equal opportunity for treatment. So why do poor New York blacks, desperately in need of health care, have to stand in line for hours at the Manhattan West Side Clinic to see a doctor for thirty seconds, when rich society ladies on the East Side have doctors begging to be the one privileged to prescribe them a tranquilizer? Our present system is decadent!"

A gray-haired man sitting directly to my right posed the question, "Can socialized medicine save us?"

Swift came the reply from the man at the chalkboard, "Yes! Health care should be free at the point of delivery; no one should be denied care because of inability to pay. This is the first principle of our socialized health system; access to health care with regard to need rather than wealth."

From my position at the head of the table, I glanced at the stern faces of those around me in the crowded conference room. All thoughts were focused intensely on the man at the front as he continued. "The second principle of our socialized system is that health maintenance should be a collective endeavor with health care consumers managing the institutions which serve them. Services of the doctor and the hospital should not be planned for the people, but by the people! This is socialism at its epitome!"

A woman's voice cried out, "But all this is just theory! What would it really be like?"

In my preoccupation I had not noticed several women standing in the far corner of the room. One of them in a red dress was apparently the source of this vocal outburst. The man at the board turned to another woman and said, "Tell her, Alice."

She responded, "It would mean that average people like you or me would sit on boards all across the country to tell doctors how we want the hospitals and clinics run. We could eliminate the ten dollar service charges and provide health service according to need without monetary influence. People would not have to go broke keeping someone in a hospital or extended care facility. We, the people, would control

the medical business."

The man at the board quickly continued, "There are some geographical areas where doctors have not been available. We need physicians in the ghettos, the big city centers, the mining towns, and the many miles of neglected rural areas. In our socialized system, areas will be specified where new doctors may or may not practice. This is our third socialist principle: a socially rational distribution of services. Of course we are not telling them where they must practice. We are simply telling them where they may not practice, and inviting them to areas that desperately need them. It will--"

The gray-haired man broke in, "Who is to do all this telling? We are not in a utopian or a socialist society. We are in a capitalist society! How can you have socialist control in a capitalist setting?"

The man at the board replied, "Until a Marxian revolution brings on a classless society, we will do our controlling through the state."

"The state?" someone asked.

"Yes," he replied emphatically, "the government. We will have a national health service until we attain full socialism."

The gray-haired man asked, "Do you think that people really want government control of the medical field?"

Alice burst out, "People want to see doctors! Poor people don't want to stand in line for hours while they're dying of a heart attack! Your capitalist system promotes these injustices!"

The woman in the red dress asked, "Well, will socialized medicine solve these problems?"

Alice replied, "Yes! We guarantee every citizen a doctor."

The gray-haired man said, "Yes, every citizen deserves a doctor. No one must be denied health care because of inability to pay. And every citizen needs food to eat! No one must be denied food because of inability to pay. We must provide free food to all citizens. And all citizens need warm coats on their backs to live through our winters! We must provide free clothing. And everyone needs shelter! We will give our citizens free health care, free food, free shelter, slap some clothes on their backs, and live happily ever after!"

A man at the end of the table added in a caustic tone, "And nobody has to pay a thing for it!"

The man at the board replied, "Of course somebody will have to pay for it. The middle class and the rich will pay weekly specified taxes."

The gray-haired man replied, "So socialized medicine is not really free service after all! It's people like us paying regular taxes to support not only themselves, but also those who can't pay, and those who sit behind desks in another government organization!"

Someone asked, "Will these weekly taxes amount to more than what we now pay for medical care?"

The man at the board replied, "It will probably be much the same."

The gray-haired man said, "I'll tell you how it will be! Those who are usually healthy will be paying more, and those who are often sick will be paying less."

The man at the end of the table quipped, "So, in other words, it will pay to get sick."

Alice's outburst was incisive. "Wait until you get deathly sick

and need to go to the hospital but can't afford to pay! You'll sure appreciate the medical help you can't afford!"

There was an uneasy silence. The woman in the red dress broke in, "But the system can't afford it either! Britain's National Health Service is deeply in debt. And since the inception of Medicare in this country in 1965, the unpaid debts have piled up to millions of dollars. The Medicaid program has a similar story. All people need to do is look and they'll realize that the government has a special talent for going into debt! Who cares about financing our medical system--let's shove it into the hands of the government!"

The man on my left, quiet until now, said, "Perhaps I can propose an alternate idea. Could the same sort of prepayment system be employed by private industry or something like Blue Cross/Blue Shield?" Not waiting for an answer, he continued, "The Health Maintenance Organization, for example, is a system that pays all medical bills when the insured family pays a standard monthly fee. It has been sponsored by the government and has been miserably failing. On the other hand, private HMO's like the Kaiser-Permanente Program and the Health Maintenance Plan of Blue Cross/Blue Shield have been used with great success."

The man at the board said, "You seem to overlook one thing. Only the government has enough money to support the hospitals, medical schools, and extended care facilities. You cannot deny it. Besides," he continued wryly, "all we need to do is to take away the capital the medical bourgeois steals from the poor. Our doctors will no longer be rich."

"So what are you suggesting?" someone asked.

The man at the board replied, "We will pay them a salary. We will pay them according to how many patients they have, how many times they treat these patients, and how difficult their cases are. The better they produce, the better we will pay them."

An uneasy stir passed through the room. The gray-haired man said, "But how do you define good production? We are not dealing with factories! Does good production mean helping sixty patients a day instead of forty, or giving forty patients quality care instead of running sixty patients through in assembly-line fashion?" He stood up and continued with a strained voice, "That's what I don't like about this socialist system! The person part of the care is eliminated!"

Alice walked up to the edge of the table. "It's no different in your capitalistic mess," she cried.

The gray-haired man replied irritably, "But it's much more probable in yours! You see, your doctor works for the government. Ours works for the people. If a patient doesn't like our doctor, he can simply change doctors. In your system, he must always go back!" Pushing his chair aside, he continued, "Efficiency and cost control are hard masters, don't you think? When was the last time you were treated like a sheep? Your socialist doctor will treat patients like animals because he receives no reward for being humane. As an advocate of a system which criticizes doctors and reduces them to nothing but money-hungry elite, you should be the least optimistic about relying on their humanistic instincts to treat their patients well. Even if your socialist patient has a hernia operation and ends up with gangreen and a scar 30 inches

long, he has to go back!" He glared at the man at the board, sat down, and quietly said, "I would go to have a cavity filled, and wake up from the anesthesia to find three teeth pulled, simply because the doctor could get more for the more difficult job. I become a sheep, and as a patient in a hospital, I become just another body in another bed, just blood and guts." There was total silence in the room.

The man at the board replied, "But at least every citizen will have a doctor. We will have gone the first step, which is more than you can claim."

The gray-haired man said, "Perhaps it is true that all people will have doctors. They will have them whether they want them or not. Who holds the responsibility if your doctor makes a mistake? Or if he becomes careless or neglectful?"

The man at the board replied curtly, "The state, of course, will monitor and hold the responsibility for all doctors."

"The state?" asked the gray-haired man. "Ha! Doctors in private practice get sued if they make mistakes. But who can sue the state? Who cares about making mistakes if there's no responsibility for making them?"

The man at the board shrugged his shoulders and replied, "But we can always fire them."

The gray-haired man returned with a loud voice, "And who will take care of his patients? How long will it take you to get another doctor to take his place?"

Alice cried out fiercely, "Well, you don't even attempt--"

The gray-haired man continued, ignoring her, "You have three

alternatives. First, you can keep the doctor and let him continue making mistakes. His patients will suffer, but your ideals will remain. Second, you can fire the doctor, and leave his patients devoid of care. Is that a very rational distribution of services? Your third alternative is to fire the doctor and force another doctor to move in. Which would you pick?" His steely eyes drilled into the man at the board, who stood in stiff silence with an icy expression. "You will pick the first, and let the patients suffer, just to save your pedantic idealism." He lowered his eyes and put his head in his hands. "And when your theories don't mean anything to you anymore," he continued, "then you will even pick the third, and resort to crude force in order to display a banner of love."

Alice opened her mouth as though ready to speak. I grasped the arms of my chair and wrenched my body from its padded cradle.

I found myself standing in the dark conference room with only fifteen empty chairs and a half-erased blackboard. My hands were clenched and perspiration beaded my forehead. I looked at my watch and realized that hours had passed since I stepped inside the room. I pulled myself out into the hallway and made my way down the corridor.

"Now I realize why I distrust socialized medicine," I thought. "It deals with the masses. It doesn't deal with drunk German ladies and old men who sing on their way to surgery. It turns everybody into just an index number on a government file. Physicians run the patients through like sheep in a Marxian production shop. Mr. Clark is no longer an expert at falling off the commode; he is just number 286 waiting to be processed, just 173 pounds of blood and fat waiting to get a scalpel in the hip.

"Now I understand the unconscious pleas of each person's face as I make my way down the hospital rooms. I realize that dehumanization away from the surgery table is much more tragic than dehumanization on the surgery table. I realize that much of medical treatment occurs when you are being handled and treated. It takes place when you try hobbling down the hall for the first time after your meniscectomy, or when your two-month-old infant has a serious case of the croup. It takes place when you lie staring at the ceiling, languishing away as an 87-year-old CVA patient with urine running down your legs while the nurses brush past your door without even caring to cast a sympathetic look in. That's when the real treatment takes place."

I walked slowly down the hospital corridor and paused to glance out one of the windows toward the east. The light of dawn peeked faintly behind the mountains.

DEVELOPMENT OF THE PROBLEM

Good health is a precious commodity, and once we have lost it, we must endure one of the greatest liabilities this life has to offer. The mighty promise of "life, liberty, and the pursuit of happiness" becomes an empty vessel that mocks and pretends when our own taxed and torn bodies chain us down. In a day when Americans are continually asserting their rights, it is not surprising that the right to health and the happy life has come to the headlines. Do we not have the right to good health care? Or is health a privilege reserved only for those who can afford to pay for it, as it now appears to be on the American scene? The old saying that good health cannot be bought or sold is being challenged, and American medicine is receiving the critical eye. The capitalist system of health care is accused of being an "obsolete, non-workable non-system."¹ Alternatives are being considered; presently 18 national health insurance bills sit on the tables of Congress, waiting only for the vote and a signature. The image of nationalized medicine is steadily gaining strength among the masses of underserved Americans.

Where will it all lead? Is there a perfect health system, or at least one that really does give "liberty and justice for all?" If we look into the history of our health dilemma, we will find that part of the problem arises in the fact that we are dealing with a very old beast.

¹Reuther, William P., "National Health Insurance: What it is, what it does, what it would mean for America," Circular published by the Committee for National Health Insurance, no date, p. 3.

The attitudes and practices which underlie the issues have been entrenched for centuries.

In ancient Greece, Plato commented on the typical practice of the private physician:

But the free-born doctor is mainly engaged in visiting and treating the ailments of free men, and he does so by investigating them from the commencement and according to the course of nature; he talks with the patient himself and with his friends, and thus both learns himself from the sufferers and imparts instruction to them, so far as possible...²

When supplemented with the ancient Hippocratic Oath, in which the physician pledged "that into whatever house I will enter it shall be for the good of the sick to the utmost of my power," this scene appears very humanistic. But the altruism of ancient medicine only extended within the boundaries of social class; the slaves were exempt from quality care, as Plato points out.

He [the free-born doctor] often left the treatment of slaves...to his subordinates, possibly to slaves themselves...The slaves are usually doctored by slaves, who either run around the town or wait in their surgeries; and not one of these doctors either gives or receives any account of the several ailments of the various domestics, but prescribes for each what he deems right from experience, just as though he had exact knowledge, and with the assurance of an autocrat; then up he jumps and off he rushes to another sick domestic, and thus he relieves his master in his attendance on the sick.³

This selective distribution of health care on the basis of social status begins a historical strand of attitudes which have continued even until today. Who will not admit that today's poor and the isolated rural people have generally been excluded from adequate health services because it is not financially lucrative to doctor them? Is not this a

²Plato, Laws, translated by R.G. Bury, Loeb classical Library, vol. 1, p. 309 (Original not seen; abstracted by Owsei Temkin, "In Early History," p. 4, In Iago Galdston (Ed.), Social Medicine: Its Derivations and Objectives (The Commonwealth Fund, New York, 1949).

³Ibid.

very subtle, and sometimes an outright, distinction in class?

The elitism of the medical profession was carried to such an extent that doctors were even considered above the law, even to the point of having a holy calling. The ancient Greek writer Lucian characterized the medical social ethic as follows:

In the case of the medical profession, the more distinguished it is and the more serviceable to the world, the more unrestricted it should be for those who practise it. It is only just that the art of healing should carry with it some privilege in respect to the liberty of practising it; that no compulsion and no commands should be put upon a holy calling, taught by the gods and exercised by men of learning; that it should not be subject to enslavement by the law, or to voting and judicial punishment or to fear and a father's threats and a layman's wrath.⁴

This attitude gave the physicians an unrestricted license to practice how or where they wanted without accepting any responsibility for eccentricity, carelessness, or neglect. This is sometimes offered as another criticism of capitalistic medicine, but it can often be more true for socialized medicine. These Greek elitist doctors were not "capitalist" physicians; they were "socialist" doctors. They worked for the government, often being hired by the cities at great cost.⁵ Their unrestricted license for eccentricity or carelessness was permissible not just because they were considered above the law, but because the government held the responsibility for their practices. As Temkin points out, "The social responsibility in medical matters lay with the city, the state, or other corporative bodies."⁶ Every socialized system today

⁴Lucian, translated by A.M. Harmon, Loeb Classical Library, vol. 5, p. 511 (Original not seen; abstracted by Temkin, p.5).

⁵See the history of Democedes as told by Herodotus, III 131.

⁶Galdston, p. 6.

has this same weakness: when responsibility is not fixed, human nature is not apt to assume it; when responsibility is not assumed, actions become irresponsible and motivation to perform well is reduced to a minimum.

In the middle ages scientific medical advancement was slow. Most illnesses were ascribed to evil spirits, and medical care was placed largely in the hands of the clergy. It was the monks, not the doctors, who wore the mantle of community respect in those days. Caring for the sick became one of the main responsibilities among the monastic orders, and Christian hospitals sprang up throughout Europe.⁷ A new sense of domestic concern, with an emphasis on charity and brotherly love, began to spread during the birth of the renaissance in the 14th century, and these hospitals became refuges for the sick, the poor, the old, and the homeless. Doctors were publicly criticized for avarice much as contemporary capitalist doctors are commonly scathed today. A German preacher active in the late 1400's, Geiler von Keizersberg, wrote the following criticism:

A physician should have compassion with everybody, especially the poor who has not much to give. He should not only help such a one from compassion and for God's sake, but he should also be at his service every day. Afterwards he may take all the more from the rich who can afford to pay.⁸

Paracelsus gave a very eloquent and severe criticism:

And it has become a doctoral custom - where scripture sanctions it as right, I know not - that a visit should cost a gulden although it be not earned; and that there be fixed fees for the inspection of urine and other things. That one have compassion with one another and fulfil the commandment of love, such things do not become use or custom. Neither is there any more law, but only grab, grab, whether it makes sense or not. Thus they receive

⁷Ibid., p.9.

⁸Kotelmann, L., Gesundheitspflege im Mittelalter, Hamburg-Leipzig, Voss, 1890, p. 203 (Original not seen; abstracted by Temkin, p. 9).

golden chains and golden rings, thus they go in silk raiment and thus display their manifest shame before all the world, which they deem an honour and well suited to a physician. To walk around thus decked out like a picture is an abomination before God.⁹

The arrival of the 18th century brought on another great surge of social consciousness. In 1697, in his Essay upon Projects, Daniel Defoe suggested a pension office for the relief of the poor, and "collective self-help," the principle of insurance.¹⁰ From 1696 to 1714 "a corporation for the relief and employment of the poor" was established in Bristol, England by an act of Parliament, and in 1714 John Bellers, a London cloth merchant, first proposed a national health service that included a plan for providing health care to the poor and the establishment of hospitals as teaching centers.¹¹ Beller's proposal, like many in the early 1700's, was primarily concerned with eliminating unnecessary sickness and deaths which depleted England's labor and military power. A hospital insurance plan was proposed by Piarron de Chamouset in 1754, and scores of economic security plans followed in the late 1700's. These were the days of the great pre-socialist reformers: Henri Saint-Simon, Charles Fourier, and Robert Owen. Many were seeking alternatives to the capitalistic system, and scores of utopian experiments flourished in the eighteenth century, including more than forty in France alone.¹² In

⁹Paracelsus: "Seven Defensiones," Four Treatises, edited by Henry E. Sigerist, Baltimore, Johns Hopkins Press, 1941, p. 31. (Original not seen; abstracted by Temkin, p. 9.)

¹⁰Rosen, George, "In the Age of Enlightenment," p. 16, In Galdston, Social Medicine.

¹¹Ibid., p. 17.

¹²Rosen, George, "Medicine in Utopia From the Eighteenth Century to the Present," Ciba Symposia, vol. 7, 1945-1946, p. 188 (Original not seen; abstracted by Rosen, "In the Age of Enlightenment," p. 22).

Britain the number of doctors was so small that other poorly trained practitioners substituted in their stead in order to serve the poor, much like what had taken place centuries before when the Greek slaves were doctored. Adam Smith described these substitutes as "the physician of the poor in all cases, and of the rich when the distress or danger is not very great."¹³

At the turn of the century nearly 10,000 insurance societies existed, and upper class paternalism caused the responsibility for the medical needs of the poor to shift from the church to the state.¹⁴ Most health movements were directed by middle-class humanists working through Chartism. Most of these were unsuccessful, however, and the century is probably best known for the ideologies of Marx and Engels which began the crystallization of present-day socialism. Shryock described the 19th century conditions as ideal for the birth of Marxian philosophy.

During the first four decades of the nineteenth century many outbreaks of cholera caused great alarm and high death rates. The health conditions of the poor appealed to the members of labour groups being influenced by pre-Marxian socialist thought. Engels, in his famous work on the condition of the English "labouring classes" (1844) insisted that "the State take action to protect the health of the masses; the workers had a right to such protection, and should not have to depend upon paternalism, the sporadic efforts of clerical charity, or bourgeois humanitarianism."¹⁵

The socialism of Karl Marx, revealed in his Communist Manifesto, was a system of political and economic policies which included the labor theory of value, dialectical materialism, the class struggle, and dictatorship of the proletariat until the establishment of a classless

¹³Smith, Adam, An Inquiry into the Nature and Causes of the wealth of Nations, London, Ward, Lock, and Co., no date (1869?), p. 101 (Original not seen; abstracted by Rosen, p. 23).

¹⁴Shryock, Richard H., "In the 1840's," p. 30-34, In Galdston, Social Medicine.

¹⁵Ibid., p. 33.

society. When translated into the world of health care, it proposes a very different alternative to the traditional fee-for-service, or capitalistic, system of medicine.

According to Marxian principles, doctors function as oppressors in our capitalist setting. Who are the oppressed? Not just the proletariat, as Marx would have it, but the entire society. Doctors, of course, control the means of production. They own the equipment, direct the hospitals, and hold the knowledge necessary to enact cures of their own choosing, cut tissues at their own pleasure, and include patients at their own will. Medical knowledge and technology therefore became the private property of the physician and gives him or her the power to exploit the "propertyless" patient. The patient must depend solely on a medical elite that holds an authoritarian monopoly on all diagnoses. This patient has no control; the doctor has all power.¹⁶

The theoretical aims of Marxian medicine would be to eliminate all class distinctions in health care relationships and to place the means of production into the hands of the working class. This would entail deprofessionalization of the elitist medical structure (bourgeois), placement of all medical facilities, including hospitals, medical schools, and extended-care facilities, into the ownership of the corporative body governing the people, distribution of health care to all citizens on an impartial, first-come first-served basis, and a thrust to allow the working class (proletariat) to participate more fully in their own preventive and diagnostic health care.

¹⁶Marieskind, Helen I., and Barbara Ehrenreich, "Toward Socialist Medicine: The Women's Health Movement," Social Policy, Vol. 6 (September 1975), pp. 34-42. Also see Ehrenreich, Barbara and John, "Health Care and Social Control," Social Policy, vol. 5 (May, 1974), pp. 26-40.

Marx predicted that polarization of the wealth would become acute enough to evoke a proletariat-caused revolution, the result being the metamorphosis of capitalism to socialism. Europe never did see his revolution occur, however, and other less sweeping proposals were enacted. The middle 1800's saw a great deal of hospital expansion, and many of the physicians, so indiscriminately execrated by Marxian socialism, gave of their services freely to the poor, one of the results of which was the Red Cross in 1860.¹⁷

In 1883, Bismarck succeeded in having the German Reichstag pass social legislation that forced health insurance on a large segment of German wage earners. His insurance system, which included a central state bank into which employers and employees would pay capitations, was described by Holborn:

As a rule the health service was set up on a local basis and the cost divided between employers and workers - one third to be paid by the employers and two thirds by the workers. The minimum payments for medical treatment and sick pay up to thirteen weeks were legally fixed. The individual local health bureaus were administered by a committee elected by the members, and here the workers won majority representation on account of their large financial contribution.¹⁸

Doctors generally did not object because the workers had often not paid their bills, and compulsory insurance would assure financial reimbursement.¹⁹ Bismarck was motivated more by his desire to improve economic efficiency and unify the German empire than by any humanitarian instincts, and his health insurance law was followed by more social legislation

¹⁷Shryock, p. 39.

¹⁸Holborn, Hajo, A History of Modern Germany: 1840-1945 (New York: Alfred A. Knopf, 1969), p. 291.

¹⁹Sigerist, Henry E., "From Bismarck to Beveridge," p. 44, In Galdston, Social Medicine.

which provided protection against the other main threats to the employee's working capacity, namely accident, incapacity, and old age. Here, as in the case of Bellers' national health service plan for England in 1714, the reasoning was that much unnecessary illness and the accompanying deaths resulted in a national economic loss due to a labor power loss. Such is often the case with political programs for the masses; humanitarianism is a sell-word behind which other, more politically-oriented goals, are desired. Certainly the German national health insurance system was not Marxian Socialism, but it was the closest thing that the German Socialists could come up with; as Holborn points out, "It was the first chance for the Social Democrats to gain a small foothold in public administration."²⁰ Traditional medicine had to recognize that socialism was here to stay; the fires of the health care dilemma were already burning.

During the early 1900's government-controlled medicine steadily gained support, and in 1911 England legislated a limited national health insurance program. With the support of Lord Beveridge, who planned a comprehensive British National Health Service in 1944, and John Strachey, the Minister of Health, the comprehensive National Health Services became law on July 5th, 1948, and England became one of the first Western nations to adopt socialized medicine.²¹

The history of Germany, which now has a government medical system administered by private insurance companies,²² and of Britain, which has

²⁰Holborn, p. 291.

²¹Allen, Gary, "Bad Medicine: Socialist Medical Care is Bad Medical Care," American Opinion (February, 1971), p.4.

²²Ibid., p. 7.

now survived for 33 years under a socialized system, shows that a national health service is usually preceded by a national health insurance program. It shows that socialized medicine, which is essentially just another name for a national health service, is too big of a pill for capitalist societies to swallow all at once. It must be swallowed by degrees, and that becomes very important when looking toward the future prospects of health care in the United States.

Sweden enacted its National Health Insurance Program in 1955, and Canada followed suit in 1968 with an insurance system administered by the country's 10 provincial governments, seven of which have now adopted the scheme.²³ Japan's national health insurance organization became compulsory in 1942, was eliminated in 1948, and was once again introduced in 1961.²⁴ France, Australia, and many other Western countries are now operating under nationalized systems, and the United States is the only major industrial nation presently without a national health insurance program.

That may not be the case for much longer, however, because the US has been moving toward a national health service since the inception of Social Security in 1935. Social Security, a program financed by a payroll tax shared equally by the employer and the employee, covers about 90 percent of the workers in the US, and pays benefits to retired or disabled workers and their dependents, and to survivors of workers who have died. In 1965 Congress passed the Medicare bill, an extension

²³Hansen, Greg, "Is it time yet?" Unpublished research paper (February, 1977), p. 5.

²⁴Higuchi, T., "Medical Care through Social Insurance in the Japanese Rural Sector," International Labor Review, Vol. 109, No. 3 (March, 1974), pp. 258-9.

of the Social Security Act which provided benefits for everyone over sixty-five, regardless of need. The Forand Bill, which was the forerunner to John F. Kennedy's Medicare program, failed to pass Congress, but of Medicare Forand himself said, "If we can only break through and get our foot inside the door, then we can expand the program after that."²⁵ The advocates of socialism in the US were elated with Medicare's proposal and passage, and the April, 1965 issue of the official Communist Party periodical, Political Affairs, stated that Medicare was "the most important piece of legislation today."²⁶

Medicaid was also adopted in 1965 and provides benefits for the "medically indigent" and covers all those dependent on welfare. The administration of this program is left to the individual states, which jointly finance the program with the federal government on a matched-fund basis.²⁷

The government next came up with the WIC program (Women, Infants, and Children) which provides free benefits to pregnant and nursing women, infants up to one year, and children up to age five years.²⁸ It is a supplemental food program that works much like the food stamp portion of the welfare system except that one need not meet the welfare requirements. After providing free services to the elderly, then to the poor, and then to the very young, the next step is to provide free health services to the entire population. Two other prelimi-

²⁵Allen, p. 14.

²⁶Ibid.

²⁷Handy, Gary R., "Medicine Leads the Way," The John Birch Society Bulletin, No. 203 (February, 1976), p. 7.

²⁸"What is WIC?" Circular published by Ross Laboratories, (March, 1976), p. 1.

nary programs, however, have been initiated by Congress in order to prepare for that program.

In 1972, federal law established the formation of Peer Review Boards under the official title of the Professional Standards Review Organization. These boards are designed to be comprised of local doctors (although this is only optional) and agents of the Department of Health, Education, and Welfare, in order to supervise the physicians who are treating the Medicare-Medicaid patients. Of this board composition the existing law in Section 1155(b) reads:

To the extent necessary or appropriate for the proper performance of its duties and functions, the Professional Standards Review Organization serving any area is authorized in accordance with regulations prescribed by the Secretary to . . .

(1) Make arrangements to utilize the services of persons who are practitioners or specialists in the various areas of medicine (including dentistry) or other types of health care which persons shall, to the maximum extent practicable, be individuals engaged in the practice of their professions within the area served by such organization. . .²⁹

The goal of these boards is to keep down rising health care costs by eliminating fraud at the primary care level. This entails scrutinizing the patient records and checking to see if doctors are following the handbook-prescribed treatment guidelines, such as proper number of days in the hospital, proper drug diagnoses, etc. As the PSRO bill was being formulated, Tom Tierney of HEW said to the physicians assembled at an American Medical Association Convention that he was glad that doctors are accepting the idea of "control" and that "control was no longer a dirty word."³⁰

²⁹Statement of the American Dental Association and the American Society of Oral Surgeons before the National Professional Standards Review Council, Washington, D.C., January 24, 1977, p. 6.

³⁰Allen, p. 16.

The final preparatory step come the following year with the Health Maintenance Organization Act of 1973. Private HMO's had actually been in existence since 1927 when a medical cooperative was established at Elk City, Oklahoma. The Group Health Association, created in 1937 as the first urban medical cooperative, now serves almost 100,000 people, and the Kaiser Foundation Medical Care Program, which is the largest private HMO now functioning, operates in six regions and serves more than 2.7 million people.³¹ The HMO is an organized system of health care in which each family or individual pays a fixed amount of money on a periodic basis for which they receive comprehensive health services ranging from preventive care to hospital treatment; each doctor receives his income from the HMO financial pool. The gamble, of course, is that most people will probably be healthy enough not to need the services while the few who do need expensive medical treatment will be adequately covered by the incoming funds of all. The HMO act of 1973 simply put government-controlled HMO's on the health care scene. The members of these systems, of course, pay their premiums to the government, and the doctors who participate receive their remuneration from the government. What we have is really just a little national health service in miniature!

So national health insurance in the United States is really not far off. The Social Security, Medicare, Medicaid, WIC, PSRO, and HMO acts have all led up to it. In 1975 there were 23 national health insurance bills before Congress, and in January, 1977 the tally was

³¹"The Prepaid Group Practice: Health Maintenance Organization," Circular published by the Group Health Association of America, Inc., no date, p. 1. Also see "Kaiser Foundation Medical Care Program/1974," Circular published by Kaiser Foundation Health Plan, Inc., no date.

almost as high at 18. The proposals range from the Long-Rubicoff bill, estimated at \$9.8 billion per year, which doesn't start paying until the patient is almost bankrupt, to the Fulton bill, estimated at \$20.3 billion per year, which is being sponsored by the American Medical Association, to the Ullman bill, \$25.1 billion, sponsored by the American Hospital Association (which, incidently, requires an HMO at every locale), to the all-inclusive, comprehensive Kennedy bill being sponsored by the AFL-CIO and UAW, which is compulsory, universal, and is the only bill that does not require any patient cost-sharing, such as deductibles, coinsurance, or copayments. The difference between a comprehensive, compulsory national health insurance program like Edward Kennedy's and a national health service like Great Britain's would be small.³²

Has the time finally arrived for America? Are we prepared to accept national health insurance which will undoubtedly lead to a national health service, as the histories of other Western nations have shown? Is socialized medicine the answer to the class discrimination described by Plato, Geiler von Keisersberg, and Marx? Will it help to stabilize the economy, as claimed by Bellers and Bismarck? If so, we had better know what we are getting into. If not, we had better know what we are trying to avoid. Lenin described socialized medicine "as the key to the arch of a socialized state,"³³ and on an issue so vital we cannot afford to rush in blindly.

³²Hansen, p. 6.

³³Allen, p. 13.

THE ISSUES

The words "socialist" or "socialized" often impinge a bad connotation with American conservatives, so when referring to medicine, it's proponents often replace it with the word "nationalized" and even deny it having any connection with the principles of socialism. For example, the late Walter Reuther, past president of the United Auto Workers, organizer of the Committee for National Health Insurance which prepared the plan now being sponsored by Senator Edward Kennedy, and one of the most powerful contemporary proponents of national health insurance, responded as follows when asked in an interview about socialized medicine:

Question: Quite a few physicians are fearful of "socialized" medicine. Need they have any fears that your national health insurance plan would fall into that category?

Answer: National health insurance isn't "socialized" medicine, though that's one of the scare words that will be used against it. The same kind of propaganda to create unreasoned, unfounded fear will be directed against national health insurance as was directed against Social Security more than 30 years ago and Medicare more recently. "Socialized" medicine means government ownership of the hospitals and other health facilities. It implies that physicians work for the government. We're not proposing this. We're proposing a nationwide insurance program-- a public system of enrollment, of financing, of acquisition of rights to the services that may be made available. But those services would continue to be provided by physicians and other private individuals, and by the private hospital system of this country. The very idea that there's even a threat of "socialized" medicine in what we're doing is out of the question. Indeed, national health insurance could be the last chance of avoiding "socialized" medicine.³⁴

It is surprising that people actually believe Reuther when he claims that national health insurance has nothing to do with socialized medicine. We have already seen that history indicates otherwise;

³⁴Reuther, p. 5.

the present-day systems in other countries also indicates otherwise. The similarities between the two are glaringly obvious, and the transition from one to the other could easily be done in the following manner: Once a comprehensive program like the Reuther-Kennedy NHI becomes law, joining the national program "would be compulsory for all."³⁵ Everyone would pay to the government through employer-employee payroll taxes (much like Social Security), and doctors, of course, would receive their remuneration directly from the government. It is interesting to note that on one hand, Reuther says that socialized medicine "implies that physicians work for the government. We're not proposing this. . .," while on the other hand his NHI plan would have doctors paid directly by the government! Since all Americans would be in the program, physicians would receive almost no income through private practice. If there's no resemblance between working for the government and receiving total income from the government, as Reuther claims, then winter comes in July. It is interesting that Reuther proposes to fight socialism by imitating it! Furthermore, private HMO's, which have grown under a system that supports pluralistic methods of delivery and diversity generated by a competitive setting, and which have attracted people only because of their reduced costs and more comprehensive prepaid services, would be stifled under comprehensive NHI.³⁶ Only government HMO's, or huge corporate HMO's subsidized by the government, would do well (which,

³⁵Carlova, John, "Reuther's strategy for a health-care revolution," Reprint from Medical Economics (July 21, 1969), p. 5.

³⁶Erickson, Robert J., "The Future of Group Practice Plans under Universal Health Insurance," Presented at a seminar of the 101st Annual Meeting of the American Public Health Association, San Francisco, California, November 6, 1973, pp. 4-5.

incidentally, would have government-owned and operated hospitals, contrary to what Reuther claims). The addition of one government law could then consolidate all operating HMO's into the umbrella of a "uniform and efficient" system much like the US Postal Service. All health personnel, including physicians, would work for the conglomerate, and probably even be unionized (which poses some interesting ramifications), while all money flow would be through the federal government. So what happens when a little government HMO, mentioned previously as a "national health service in miniature" (p. 25), becomes a big, conglomerate, national HMO? Socialized medicine would be a fact of life in the US, the national health insurance program would have evolved into a National Health Service, and Hegel would be verified correct when he said that we learn nothing from history except that we learn nothing from history.

Another big factor would favor a transition like this: dissatisfaction with one government program, accompanied by claims that it is inadequate, usually leads to the proposal and enactment of more comprehensive government programs. This is borne out by several examples from the big push for a NHI program. As Carlova points out in his affirmation of the Reuther-Kennedy plan:

The breakdown of Medicaid, in fact, is viewed by one leading health care planner as the trigger that may produce popular and legislative support for Reuther's plan for national health insurance. "We're in a very serious bind with Medicaid," says Jerome Pollack, professor of the economics of medical care at Harvard Medical School. "The cutbacks and general retreat of Medicaid may spur action for universal health insurance."³⁷

Another example can be taken directly from the Hearings on the HMO

³⁷Carlova, pp. 3-4.

issue before the House Subcommittee on Health and the Environment:

Mr. Carter. What are the ultimate goals of HMO's?

Mr. Ahart. As I understand it, the intent of the Congress was to make this alternative form of health delivery and financing available to large segment of the population in competition, so to speak, with the more traditional forms of delivery of health care. . . It has been suggested that perhaps until we get to a national health insurance program it may not be possible to do everything that we want to do or that Congress wants to do with the HMO standing alone.³⁸

And again, several paragraphs later,

Mr. Ahart. . . .As I suggested in response to an earlier question, quite a number of people believe that to go to these requirements. . . simply in the context of the HMO program may not be realistic. We might have to await to accomplish some of the purposes that Dr. Carter was referring to for a national health insurance program of some kind that would equalize for everybody in the business the requirements. . .³⁹

This attitude was epitomized by Forand after John F. Kennedy's White House conference on the issue of Medicare: "If we can only break through and get our foot inside the door, then we can expand the program after that."⁴⁰ Medicare has turned out to be a bankrupt failure, Medicaid has turned out to be a bankrupt failure, and the government HMO program has been strangled with so many problems that only 5 HMO's were created the first 2 years of operation, and these have also ended up to be financial fiascoes.⁴¹ So we ride the merry-go-round, Medicare to Medicaid to PSRO to HMO to NHI to NHS, and all the while thinking that the cure to government program failures is

³⁸U.S. House of Representatives, Hearings before the Subcommittee on Health and the Environment on HR 7847 and HR 8428, 94th Congress, First Session, Washington, D.C., July 14 and 15, 1975, p. 30.

³⁹Ibid., p. 37.

⁴⁰Allen, p. 14.

⁴¹U.S. House of Representatives, p. 17.

bigger government programs. That is why a national health service will follow national health insurance. That is why all references to a national health service or a universal, comprehensive national health insurance, as well as to the components of these programs, mean "socialized" medicine.

Tragedy in this case does not lie in the issue of whether socialized medicine is good or bad; that issue will be discussed shortly. The tragedy here lies in the denial of the relationship between socialized medicine and government programs like NHI, and in the fact that many Americans are duped into believing it.

Most Americans see only their doctor's office, their doctor's new car, and the crushing doctor and hospital bills they receive after going through medical treatment they had no choice but to buy. It is the tremendous expense of American medicine which is driving many Americans toward socialized medicine. The cost of filling prescriptions, having a baby, having surgery, keeping a member of the family in extended hospitalization, or paying insurance is overwhelming. Total health-care costs have been rising at about 15 percent each year, which is more than twice the national inflation rate.⁴² From 1965 to 1974, total spending on health care increased from \$39 billion per year to \$104 billion, from 5.9 percent of the Gross National Product (GNP) to 7.7 percent.⁴³ Translated into individual terms, health-care costs are now averaging \$700 per year for every American

⁴²"Carter seeks hospital cost lid," The Salt Lake Tribune, April 26, 1977, Section A, p. 1.

⁴³Enthoven, Alain C., "Can We Control the Cost of Health Care?" The Stanford Magazine, (Fall/Winter, 1975), p. 14.

man, woman, and child.⁴⁴ The total cost of a single open heart operation often exceeds \$5,000, the cost of dialysis for patients with kidney disease is \$10,000 per year, and a prolonged terminal illness such as cancer can crush a person into absolute bankruptcy.⁴⁵ Some hospitals are charging over \$100 per day for a room; hospital costs now represent 40 percent of annual health care costs, which are expected to total \$160 billion dollars in 1977.⁴⁶ It is with bullets like these that the proponents of socialized medicine shoot the present system. Says Jerome Pollack, "The cost of health care is now so high that universal coverage is a necessity."⁴⁷

Is there any possible capitalistic defense against these glaring cost runaways? Alain Enthoven gives this explanation:

Of course, much of this increase in per capita spending should be a source of legitimate pride, not a cause for alarm. As a nation, we made a conscious decision a decade ago that the poor and the elderly should have financed access to medical care at public expense. Thus, Medicare and Medicaid, plus the large increase in private insurance coverage made medical care available to many people not previously covered. Part of the increase is the result of bringing health care workers' pay up to the level of other industries. Part of the increase is the result of advances in medical technology, much of which has been beneficial. And part of the increase is the result of society's placing on the medical care system responsibilities (such as care for alcohol and drug abuse) formerly considered the domain of other public services.⁴⁸

What does socialized medicine plan to do to control these costs?

⁴⁴"Carter seeks hospital cost lid."

⁴⁵Hansen, p. 1.

⁴⁶"Carter seeks hospital cost lid."

⁴⁷Carlova, p. 4.

⁴⁸Enthoven, Alain C., "Prepaid Group Practice and National Health Policy," Keynote Address: 1976 Group Health Institute, p. 3.

It is said that government legislation will "give hospitals some incentive to limit their own costs. . .by eliminating some of the nation's 100,000 unnecessary hospital beds, by managing money more carefully, by making efficient use of energy, and by sharing some sophisticated equipment with other hospitals."⁴⁹ According to Reuther, hospital control is just one area among many that will keep costs down.

Increased stress on prevention, elimination of economic and other barriers to early diagnosis and treatment, introduction of more effective controls on hospital utilization, payment for appropriate alternative care in place of hospitals, such as ambulatory care rather than bed care where medically safe and care provided by nursing homes and home health services--these measures could hold down health care costs.⁵⁰

His argument can be further reinforced by the success of the Kaiser Foundation's HMO in keeping costs down:

In 1967, the National Advisory Commission on Health Manpower found that after allowing for such factors as Kaiser's lower than average of aged and indigent, ". . .it appears that the cost to the average person who obtains medical care through Kaiser is 20-30 percent less than it would be if he obtained it outside. . .Kaiser has been able to achieve substantial savings because it has been able to get individual physicians to control the costs of providing medical care." Numerous evaluation of prepaid group practice plans have reached similar conclusions in the eight years since then.⁵¹

These are very astounding findings and flash a ray of hope on the cost containment problem. But they are only supportive of private HMO's; it is doubtful that they would be true for a socialized prepaid conglomerate in lue of the recent failure of the government HMO's.

⁴⁹"Carter seeks hospital cost lid."

⁵⁰Reuther, p. 8.

⁵¹Enthoven, "Can We Control the Cost of Health Care?," p. 17.

This conclusion is further substantiated by the farce of cost control in other government programs such as Medicare and Medicaid. During the first three years of Medicare, the government spent about \$11 billion for the hospital section of the program and just under \$5 billion for the supplementary medical portion.⁵² The HEW experts had declared that Medicare would cost \$2.0 billion per year, and in 1970 alone it cost \$7.8 billion with the combined Medicare-Medicaid program costing \$14 billion.⁵³ In 1971 Senator John Williams stated that ". . .the total costs of parts A and B of Medicare during the next 25 years will equal or exceed the present national debt of about \$370 billion. The latest report of the trustees of the hospital insurance fund states that under present financing that fund will be broke by 1976. . .⁵⁴ It is now 1977, the fund has broken, and the government has once again reaffirmed its economic expertise. The ironic part of the situation is that, in 1974, the average person age 65 and over spent more for medical care out of his own pocket than he did in 1966, before the gears of Medicare started cranking!⁵⁵ If the government has not been able to control the cost of the limited government programs, the question arises as to how they can claim to control the cost of a comprehensive program!

Of course, if someone is to receive the blame for these increased

⁵²Grasso, Ken, "National Health Insurance: A cure worse than the disease," Circular published by Young America's Foundation, no date, p. 7.

⁵³Allen, p. 16.

⁵⁴Ibid.

⁵⁵Enthoven, "Can We Control the Cost of Health Care?" p. 14.

costs, it is going to be the doctors. It has been widely reported that 2500 doctors sponged \$25,000 or more from Medicare in 1968. It was not mentioned, of course, that this represents only 3 percent of the doctors treating Medicare patients, nor that most of these doctors specialized in treating older patients, nor that only 2 doctors had ever been convicted of fraud.⁵⁶ It has also gone unreported that the records of the Social Security Administration reveal that during 1969 doctors received only 18 cents of each Medicare-Medicaid dollar.⁵⁷ It is unfortunate that some doctors do stoop to cheating the government; certainly the thousands of people happily and illegally sponging off the welfare program will be glad to see that somebody is getting the shaft!

In order to control fraud at the primary care level, the massive PSRO system was organized along with another bureau to manage it. Ceilings were placed on doctors' fees for Medicare and Medicaid in January of 1969, and the costs still kept spiraling. The hospitals were then indicted, but the results were again the same, and direct price controls in the health care industry were abandoned in April, 1974.⁵⁸ Enthoven proposed a lucid explanation of why these controls will not work.

If the government controls hospital cost-per-day, the hospitals can reduce cost-per-day (and increase total cost) by keeping patients longer. If the government controls cost-per-stay, the hospitals (with cooperation from their medical staffs) can reduce average cost-per-stay (and increase total cost) by admitting more low-cost cases such as tonsillectomies. And, in the long

⁵⁶Allen, p. 16.

⁵⁷Ibid.

⁵⁸Enthoven, "Can We Control the Cost of Health Care," p. 16.

run, there is simply no way that the government can effectively control the total cost of physicians' services by controlling fees, because there is no precise way of defining a physician's service or establishing the need for it. (For example, the physician can tell his patients to come back and see him "next week" instead of "next month.")⁵⁹

The newest plan of attack against hospitals is the hospital cost lid proposed by Jimmy Carter in Congress on April 25, 1977. The legislation would limit the overall increase in hospital bills at most facilities to 9 percent per year beginning on October 1, 1977, as opposed to the present 15 percent inflationary rate.⁶⁰ If it saves \$2 billion the first year and \$5.5 billion by 1980 like Carter claims it will, then perhaps this is a partial answer to the cost-containment problem. Any move in this direction will bring some relief to those who have had to pay an arm and a leg for hospital care; now they must only pay an arm. Americans in general will certainly buy the program.

It is interesting that Carter termed the plan "the first step in making national health insurance financially feasible," and even more interesting that HMO and government hospitals are exempted from the law, both of which further illustrate the national trend described earlier. The irony of the situation is that government hospitals are excluded, and it is a well known fact that government hospital employees are among the highest paid in the nation. For example, R.N.'s and L.P.N.'s wait months for employment at the V.A. hospital in Salt Lake City, rather than work at other Salt Lake hospitals where they could be hired in a day, simply because it is financially lucrative to work there! It is too bad that the federal bureaucracy never looks toward

⁵⁹Ibid.

⁶⁰"Carter seeks hospital cost lid."

itself for financial purging, especially since it needs it the most! In an interview, Nolan Kerr, Assistant Administrator of the Logan Hospital, said that Carter's proposal would put his hospital into a bind, catching them between operating expenses, 62 percent of which goes to labor (minimum wage being set by the government) and 15 percent of which goes to suppliers (who, incidently, have no controls on product prices), and the income from patient bills, now being limited to 9 percent by federal law.⁶¹

Kerr also gave a local example, namely the new Tremonton hospital, of how effective the government has been in holding down its own administration costs. The original cost of the hospital, \$1.1 million, could be only partially met with \$900,000 from the local communities, and a grant of about \$218,000 to make up the difference was sought from the government. After finally cranking through the government bureaucracy for over a year, inflation had raised the cost to \$1.5 million, the government made up the difference with a grant of \$618,000, and Tremonton got a hospital with 4000 square feet less than what they had originally asked for. That one year lapse cost taxpayers \$400,000, and it all went to bureaucracy!

The expense of the vast bureaucracy necessary to oversee socialized medicine would be tremendous. If other federal programs can be used as an indicator, there would be one \$12,000-per-year bureaucrat for every operating physician. The administrative cost of Medicare-Medicaid is estimated already to be greater than the physician cost, while the administrative cost of private insurance programs runs at only about

⁶¹Kerr, Nolan, Assistant Administrator of the Logan Hospital, Personal interview, April 29, 1977.

30 percent of the premium.⁶² One recent government study showed that it cost the government twice as much to process the average Medicare claim as it cost private insurance companies.⁶³ This seems to be another plug for private health carriers, which have always fared much better than government carriers as far as efficiency and cost control goes.

A counter-argument in favor of cost-control under socialized medicine is that it "would alleviate the paper-work barrage from the 1,785 different health insurance carriers, each with varying conditions of eligibility and coverage."⁶⁴ An opponent of socialized medicine gives the opposite opinion:

Due to the creation of Medicare. . .paperwork for physicians has increased manyfold. This increasingly burdensome paperwork has resulted in the employment of new personnel and the addition of new equipment. "Twenty years ago," Marvin Edwards quotes a Maryland physician as saying, "I had one girl to answer the phone, do the paperwork, and assist me. Now I have three people. One answers the phone and does the billing, another handles the paperwork, and another helps me."⁶⁵

Dr. Elizabeth Wilson offers the following comment on Medicare's paperwork:

Medicare's intricate billing procedure. . .continues to cause monumental accounting headaches and has necessitated the hiring of armies of new clerks. This was certainly an important factor--if not the prime one--for last year's rise of 16.5 percent in hospital costs; the annual increase for the pre-Medicare years of 1960-1965 averaged only six percent. An investigation of the situation in New York City revealed that while the average charge of outpatient claims was less than two dollars the cost of processing some of them ran as high as nine dollars! The paper:

⁶²Allen, p. 12.

⁶³Grasso, p. 15.

⁶⁴Carlova, p. 5.

⁶⁵Grasso, p. 8.

tail wags the federal dog.⁶⁶

When Nolan Kerr was asked how the added paperwork of Medicare affected Logan Hospital, he replied that because of its already efficient clerical procedures there was no great affect on the hospital either way. He added that perhaps the paperwork was an asset in some areas because it forced medical facilities to keep good records. Clearly, then, this facet of government medicine seems to give neither side a clear-cut advantage.

There is one definite area, however, that literally crucifies the cost-containment promised by socialized medicine. It goes back to the ideology of the system, and is therefore intrinsically operating in every socialized system. It is introduced quite adequately in Senator Kennedy's NHI bill.

Sec. 2. (a) The Congress finds that--

- (1) the health of the Nation's people is the foundation of their well-being and of our Nation's strength, productivity, and wealth;
- (2) adequate health care for all of our people must now be recognized as a right; and
- (3) a national system of health security is the means to implement that right.⁶⁷

The American Public Health Association, in its "Resolutions and Policy Statements," reaffirmed its support for a national health service in order "to insure health care as a social right. . ." ⁶⁸ If health care is a "right" as public opinion is now certifying, then certainly it

⁶⁶Dunham, William E., "Stop Socialized Medicine," Circular published by The Review of the News (Belmont, Massachusetts, July 1, 1970), p. 3.

⁶⁷U.S. Senate, Senate Bill S. 3, 95th Congress, First Session, Washington, D.C., January 10, 1977, pp. 1-2.

⁶⁸"Resolutions and Policy Statements," American Journal of Public Health, Vol. 67, No. 1 (January, 1977), p. 84.

should be available to everyone, regardless of "sex, age, earning ability, or race. . ."69 This is by far the most powerful argument for socialized medicine and is supported by the generally-accepted principle that "all men are created equal," or at least that all men should have equal opportunities for a happy existence. A national health system would guarantee this health care right because services would be free at the point of delivery; no one is denied access to health care because of his inability to pay. The cost of such a program would be covered through taxes, or as explained by Reuther, "contributions from employer-employee groups, from general government revenues, and from appropriate government agencies for the poor and marginally employed."70

The difficulty comes in attempting to make such a system work. The government, and, in fact, no government, is capable of feeding the insatiable demands of a populace which clamors for "rights" while simultaneously denying any responsibility to earn them. A "right," it is claimed, need not be earned; it is bestowed upon an individual simply because he is a human being. Food, clothing, and adequate shelter are also considered social "rights," and it brings to mind the possibilities of a perpetual "welfare state." It also leads one to wonder how many of these demands it will finally take to break the government camel's back.

⁶⁹"Health Care Services: A Position Paper," Circular published by the National Women's Political Caucus, no date, p. 2.

⁷⁰Carlova, p. 5.

The reason why cost-control falls apart under such a system is already apparent. When any group of citizens believe they have a right to certain services or products at little or no expense to themselves, the demands for those goods and services will increase dramatically. Increased demand in a marketplace with an inflexible or limited supply always causes an increase in prices.⁷¹ An analogy is suggested by Robert Welch:

Just suppose that the government should take steps to eliminate all fares on our media of transportation, so that free travel became everybody's right. And that this was done through varied and multiple arrangements by the government with all the different airlines, railroads, bus companies, subway systems, and operators of taxicabs. The immediate and continuing increase in the number of passengers would, of course, completely stagger the whole transportation system. And those who really needed to travel would have to stand in line or wait their turn, for hours or days or even months, along with all of the time-killers who had nothing better to do.⁷²

What happened when old age benefits became a right to everyone aged 65 and older?

Between fiscal year 1967 and 1971 the number of hospital admissions per thousand persons enrolled under Medicare increased from 266 to 309, or better than 15 percent. Between 1967 and 1969 there was a ten percent increase in the average length of hospital stay. The result was that just between 1967 and 1969 the total number of hospital days paid for by Medicare jumped almost 25 percent.⁷³

The effect of this over-utilization on Medicare's total financial expenditures has already been described. Suffice it to say that Medicare, which was not to cost over \$5 billion per year, is now costing over \$14

⁷¹Handy, p. 6.

⁷²Welch, Robert, "Danger for the Doctors," American Opinion reprint, (The John Birch Society, San Marino, California, 1970), p. 3.

⁷³Grasso, p. 7.

billion per year, with estimates that the costs will hit \$20 billion in the next several years.⁷⁴ The records show that a minimum of 40 percent of these expenditures were due to "higher utilization of services than had been assumed."⁷⁵ What happened when medical benefits became a right to the "needy"?

Between 1968 and 1975, the number of Medicaid recipients increased from 8 million to 24.7 million, while federal and state outlays increased from 3.7 billion dollars to more than 12.6 billion dollars. Indeed, Medicaid nearly has bankrupted some state governments.⁷⁶

Overutilization of services was also a problem when union members became totally covered by company-provided insurance. One physician pointed out:

Since no fee is involved people come into the office every time they have the sniffles or need a Band-Aid changed. It costs an insurance company and the doctor about \$10 in administrative costs alone for a call that the person would not make if he were paying for it himself. . . I practise near a General Motors plant. Absenteeism there runs three or four percent from Tuesday through Thursday and fifteen percent on Fridays and Mondays. . . Since they get a given number of days a year in sick pay they use every day of it and it doesn't cost them anything. All of this only seems to escalate the cost of medical care and crowd doctors' offices with kooks and malingerers.⁷⁷

And even Dr. Sidney Garfield, founder of the Kaiser health plan and the largest private HMO in business, has noted that:

Prepayment makes medical care a right by eliminating fee-for-service, and for years we have been deeply concerned with our relative inability to keep up with the soaring level of demand that this right produces, and to maintain a level of service satisfactory to us.⁷⁸

⁷⁴Handy, p. 6.

⁷⁵Grasso, p. 7.

⁷⁶Handy, p. 7.

⁷⁷Allen, p. 12.

⁷⁸Grasso, p. 20

Overutilization has a much greater effect, however, than to escalate costs. It affects the quality of care, and in times of medical crisis, that becomes a much more important consideration than cost. The effects of overutilization on quality will become quite evident as we scan the socialized medicine operating in other countries.

(Analysis of the cost of socialized medicine indicates its practicality; analysis of the quality indicates its desirability.) Clearly socialized medicine is not practicable, but on the other hand, does its quality make it desirable? Certainly socialized medicine is the only system that guarantees medical care for everyone, and as far as the egalitarian commitment is concerned, there is no other system that can match it. (If quality is first measured by the percentage of population reached, then socialized medicine is desirable. It is said that 30 million Americans are not being reached by any form of health insurance, and that two-thirds of all health care costs are not being handled by private insurance.⁷⁹) Those who don't have the insurance are probably the ones who need it the most. A survey has shown that people with an annual income of less than \$4,000 make use of medical services only slightly more than half as often as families with larger income.⁸⁰ There are countless stories such as the following one told by Richard Margolis.

The desperate shortage of health-care personnel in some areas works to strengthen local medical oligopolies, inviting its practitioners to profit at the patient's expense. I came across an instance of how this can occur, and the misery it can cause,

⁷⁹Reuther, p. 3.

⁸⁰Hansen, p. 2.

when I interviewed a woman who lives in the hills of eastern Kentucky. One day, she told me, her 4-year-old son, Danny, complained of a pain in his stomach. "I didn't have much money, but Danny was in awful pain, so I paid somebody to ride me into Prestonsburg. The doctor, he looked at Danny. He said the boy had to be operated before his appendix ruptured, but first I had to work things out with the hospital director. He told me it would cost \$350 and I would have to give him a \$100 down payment. I said I didn't have no \$100. He said, 'Well, when you get it come back, and we'll fix your boy up.' My Danny was vomiting right there in the director's office. He was real sick. I went and borrowed the money from a cousin, and I came back with the money. The director, he says, 'You have to show you got an income so as you can pay the debt.' I said all I ever get is a check every month from the Veterans fo \$57. He said that would be just fine. Then he made me sign a paper promising to turn over the check to him each month till the bill was paid. I couldn't fight him. My Danny had to be operated."⁸¹

Certainly the Medicaid program has been beneficial in bridging the gap to help families like the one described above. In 1968 an average of 114.5 low income Americans per 1000 were hospitalized, as compared with 95.4 middle income Americans. In 1969, the average low income American saw a physician 4.6 times, while the average middle income American saw one only 4 times.⁸² A completely socialized system would do even more to reach those who are now being left out.

But the road to socialized medicine is really a series of trade-offs. Everyone would eventually have access to health care, but spreading out the available medical care to everyone severely reduces the quality of care each person receives. The more patients the doctors see, the less time they can spend with each one. The more patients that influx the system, the less the system can give to each one. It is argued that that is the only fair way; if anyone must suffer, then everyone must suffer. That is the ideal egalitarianism.

⁸¹Hansen, p. 2.

⁸²Grasso, p. 11.

But is impartiality always justice? Should the idler "eat the bread" of the worker? Should he who refuses to work receive the same benefits (and "rights") as he who is willing to work? Certainly charity is giving to those who cannot afford to pay, but is it giving to those who will not afford to pay? (Can the limited medical funds be spread to include so many people, and as much utilization of services that those people fancy to use, that the "soup becomes too thin to feed anybody?" Can quality be watered down so much that service becomes cattle-car mass medicine and those who really need it die standing in line? Again, is impartiality always justice?)

Perhaps we should let the existing systems of socialized medicine speak for themselves; an examination of socialized care in other countries will provide answers to most of these questions. The key issues of health care should be kept in mind as we explore these systems: Has the system succeeded in making health care available to all as a matter of right? What have been the effects of overutilization, paperwork, and increased bureaucracy on the cost-containment and quality of the system? Has the total quality of care increased or decreased, and how have the patients and doctors reacted to the systems? Would a similar system be financially possible in America? And finally, does the United States want a system like these? These are the questions whose answers will indict or vindicate.

The most publicized of all socialized health systems is the NHS of Britain. In 1948 it was created with the idealistic dream of being ("a health service providing full preventive and curative treatment of every kind to every citizen without exceptions, without remuneration limit and without an economic barrier at any point to delay recourse

to it."⁸³) Of course the patient turnout was massive, and by 1949 the system was costing 52 million pounds over original estimates.⁸⁴ In pre-National Health Service Britain, the expenditures for medical care were only 180 million pounds per year; by 1960, they were 900 million pounds--a five fold increase during a period when the cost of living only tripled.⁸⁵ Translated into dollars and cents, the British system, originally planned to cost \$500 million per year, cost double that the first year, and by 1971 cost the taxpayers 7 times what the planners claimed. With inflation discounted it is still 3 times greater than the original promoted cost.⁸⁶ It now costs \$8.2 billion per year and represents 10 percent of all public expenditures.⁸⁷

Yet Britain's system has been widely publicized for its ability to control cost, and other statistics seem to substantiate some justification for these claims. Since 1950, after recuperating from the original overutilization shock, the British government claims that it has held its health-care spending to only 5.5% of its GNP.⁸⁸ In 1971, England was spending on medical care only \$77 per capita as compared with the U.S. figure of \$294.⁸⁹ Even more astounding is the fact that each Briton now pays only \$4 per week in taxes for health care!⁹⁰

⁸³Ibid., p. 16.

⁸⁴Ibid.

⁸⁵Dunham, p. 3.

⁸⁶Allen, p. 4.

⁸⁷Hansen, p. 3.

⁸⁸Grasso, p. 7.

⁸⁹Allen, p. 4.

⁹⁰Hansen, p. 3.

(The British must have cut corners somewhere. Where did they, and did it have any effect on the quality? Between 1948 and 1962, not a single new hospital was constructed in all of Great Britain! Two-thirds of the British hospitals were constructed before 1890, and two-thirds of those are over 100 years old.⁹¹) Paul Harvey observed:

In the 17 states of the Southern region of the United States (an area equal to the United Kingdom in population) there have been 515 new hospitals constructed since World War II. In all of Britain, they have built only 10 new hospitals since the big war.⁹²

This is certainly a good example of cost-containment, but its toll on quality medical care has been tremendous. Congressman Robert Bauman described the conditions in many British hospitals as, "at best, medieval," and he tells stories of operating rooms with "no air conditioning, no antiseptic atmosphere, loose swinging doors which opened out into public corridors, steam radiators clamped to the walls, and one sink." He tells of one hospital administrator who responded to charges that his century old hospital was infested with cockroaches, by stating that, "of course we have cockroaches, but no more than any other hospital."⁹³ A London Daily Mirror story on the NHS told of patients even holding cockroach races in filthy corridors!⁹⁴

The English journalist Anthony LeJune says that under the NHS "the average wait for a non-urgent operation is 22 weeks, and the waiting period may even stretch to years."⁹⁵ Russell Kirk said in National

⁹¹Grasso, p. 17.

⁹²Allen, p. 6.

⁹³Grasso, p. 17.

⁹⁴Handy, p. 13.

⁹⁵Allen, p. 5.

Review:

Why, more than half a million British people are on long waiting lists for hospital services--and this backlog grows greater daily. Patients may have to wait seven years for treatment of hernias or varicose veins. . .Some ten thousand elderly folk are on hospital waiting lists, and not a few of these will not live long enough to find a hospital bed.⁹⁶

The waiting period for tonsillectomies is up to 22 weeks, for hemorrhoids usually 2 years, and for plastic surgery up to 8 years! It takes 9 months just to get an appointment with an orthopedic surgeon. According to government estimates, one fourth of the individuals on waiting lists have been there for over 2 years.⁹⁷ Recently one hospital, with 20 unconscious patients on its waiting list, "sent a trained health visitor round to assess the priority of these cases. . ." ⁹⁸ Private Practice quoted a prominent British doctor concerning the effects of this crowding:

Dr. Charles Loehry, chairman of the medical staffs at Poole Hospital and Royal Victoria Hospital, both in Bournemouth, said that crowding has led to patients who might otherwise have lived dying at home before they can be admitted; patients dying in the emergency rooms after waiting up to six weeks for treatment while their tumors spread; and emergency cases smuggled into beds of patients being operated on, so when they return from surgery there is no room for them. Doctors call this "musical beds."⁹⁹

In a personal interview, Mike Adduddell, a missionary in England for several years, said that a close friend went for abdominal surgery in an NHS hospital, and upon returning from surgery to his hospital room, found another newly admitted patient, who appeared active and alert and

⁹⁶Dunham, p. 2.

⁹⁷Grasso, p. 16.

⁹⁸Ibid.

⁹⁹Handy, p. 13.

was not to go to surgery until the following day, occupying his bed. He had to wait in a chair until another hospital was located, and ride 22 miles in an ambulance through slow traffic and bumpy roads to get there. And all of this on the first day "post-op," when most patients are so nauseated they can't even get out of bed to go to the toilet!¹⁰⁰ Oh glorious socialism!

Enoch Powell, Minister of Health in England from 1960 to 1963, pinpointed the problem in his book A New Look At Medicine and Politics:

There is a characteristic of medical care that makes its public provision exceptionally problematic. The demand for it is not only potentially unlimited; it is also by nature not capable of being limited in a precise and intelligible way.¹⁰¹

Of this same problem Russell Kirk said:

The demand for medical attention, like many other demands, is insatiable--supposing the commodity is free to the consumer. Since the British patient pays nothing to the doctor, except through his compulsory national health insurance deduction, the patient demands services with a frequency he would not think of demanding, did he pay even half the cost of attendance.¹⁰²

How has this overutilization affected the doctors?

The NHS provides a windfall for hypochondriacs who want company or sympathy and for malingerers seeking a vacation from work. Anthony LeJune reports that "General practitioners have to spend an intolerable amount of time form-filling and catering to people who treat their National Health Service doctor as an automatic supplier of aspirins, tranquilizers, laxatives, and vitamins. They see almost as many patients in a day as an American doctor sees in a week."¹⁰³

Using British government statistics, Paul Friggins has determined that the average British general practitioner spends only $6\frac{1}{2}$ minutes per

¹⁰⁰Adduddell, Mike, Missionary to Central England during 1972-1974, Personal interview, October, 1976.

¹⁰¹Allen, p. 5.

¹⁰²Dunham, p. 1.

¹⁰³Allen, p. 5.

patient per consultation.¹⁰⁴ Doctors are paid by a formula centering on the number of patients they treat. They are paid about \$3.46 per year per patient, and the average general practitioner nets about \$10,500 per year for having about 3000 patients on his list. Top specialists reach the highest pay grade of 12,000 pounds (\$25,000) after 15 years.¹⁰⁵ Dr. Marjorie Shearon, a legislative specialist on health care has observed:

Today, British general practitioners are in a sorry state. Their income is wretched. The better the service they give, the poorer is their remuneration. . .Physicians in Britain depend on the size of their lists of patients, not on the number or quality of services rendered.¹⁰⁶

Dr. Lloyd Dawe, one of many British doctors who have immigrated to the U.S., said of his experience in the NHS:

Since medical care theoretically was available to everyone at anytime, we were literally swamped with patients, many of them with trivial complaints or with no ailment at all. . .Besides the heavy patient load, the time spent on government paper work was fantastically high. . .Form-filling and correspondence with the government thus became one of the physician's major functions. He was reduced to the role of part-time clerk. . . As an intern in a London hospital and later in general practice there, I witnessed the unbelievable waste, interference and bureaucratic regimentation that have accompanied Britain's unwieldy social experiment. I paid government-imposed "fines" for prescribing the best medicine for my patients. I spent anxious hours in search of hospital space for the critically ill. . .Practice under the National Health Service soon became intolerable for me, as it has for thousands of British and European doctors who have left their countries to practice in America. . .¹⁰⁷

Ken Grasso verifies Dr. Dawe's position with the following information:

Paperwork, a major problem since the inception of Britain's

¹⁰⁴Grasso, p. 17.

¹⁰⁵Handy, p. 13.

¹⁰⁶Allen, p. 6.

¹⁰⁷Ibid., p. 5.

system of socialized medicine, has become increasingly burdensome in recent years. According to one London newspaper, "There are 182 management committees in charge of hospitals, 157 executive councils acting as 'watchdogs' over local doctors, and 214 local authorities operating community health services. Not surprisingly, many observers have described Britain's doctors as being 'buried in red tape and government forms.'"¹⁰⁸

How have the doctors responded to such a system? At the creation of the NHS, Lord Horder spoke of the British physicians' general feeling this way:

It appears that "we physicians have taken in the United Kingdom vis-a-vis the Socialist intention to nationalize our medical health services and make the doctor a civil servant. We had hoped that it would be through the more natural process of evolution, rather than through the method of revolution that is now being adopted. . . We believe that we could have set up health centers without sacrificing the doctors' liberty. . . You cannot stereotype medicine without a great deal of sacrifice. It is very easy to level down; it is very difficult to level up. If I were asked to state in brief terms what is the nature of the anxiety facing our profession today in Britain, I would say that it lies in a realization of the tremendous centralization of power. . ." ¹⁰⁹

And again, several paragraphs later:

. . .there are many of us in Britain who think that this freedom should not be secured by nationalizing medicine. We consider that such a policy would lose to medicine two of its most virile characteristics--individual initiative and the spirit of adventure. . .control is very frequently an insidious form of compulsion. . ." ¹¹⁰

That is exactly what has happened in Britain since 1948. The traditional ethos, ideals, and attitude of the profession, formed at a time when the doctors were independent practitioners responsible only to their client and to their colleagues, has not mixed well with the

¹⁰⁸Grasso, p. 18.

¹⁰⁹Horder, Lord, "The Appeal of the Common Man," p. 280, In Galdston, Social Medicine.

¹¹⁰Ibid., p. 286.

reality of employment in a State service.¹¹¹ The incentives for personal creativity, initiative, and concern for the patients have been lost in a midst of government regimentation and removal of all financial, personal, and social rewards. In October of 1975, 15,000 of Britain's 23,000 physicians went on strike protesting the "dictatorship" of the Social Services Department.¹¹² The rest of Britain's doctors have been speaking against socialized medicine with their feet:

Over the past decade, an average of five hundred doctors have left the United Kingdom every year. This number grows apace. Today, the British National Health Service has 750 fewer general practitioners than it had five years ago, despite the increase in population; while the number of specialists and consultants, too, is inadequate. . .¹¹³

Before World War II there were 44,000 doctors in Britain, and that number has dwindled down to the present 25,000.¹¹⁴ Each year Britain loses 30 percent of its medical school graduates to Canada, Australia, and the United States; many a British medical student picks up his diploma and his airline ticket the same day!¹¹⁵ Each year two examinations are given to qualify British doctors for practice in the U.S.; in 1972, 404 doctors took the test; in 1973, 828; in 1974, 1019; and in 1975, 2517 doctors took the test.¹¹⁶ As a result, Britain has been

¹¹¹Klein, Rudolf, "The Profession of Medicine," Political Quarterly, Vol. 46 (July, 1975), p. 338.

¹¹²Hansen, p. 3.

¹¹³Dunham, p. 1.

¹¹⁴Allen, p. 12.

¹¹⁵Ibid., p. 6.

¹¹⁶Handy, p. 13.

filling its vacancies with doctors from countries like India and Pakistan, until now nearly half of all junior posts in Britain are filled by foreign doctors.¹¹⁷ It is interesting that in the midst of such physician discontent, in the midst of such bureaucratic harassment, paperwork, and red tape, in the midst of such scrambling to get the patients through the assembly line, the proponents of socialized medicine comment as follows on the advantages for physicians in socialized medicine:

Would practicing physicians have to work within the plan? I should think they'd want to participate. . . After all, it's in their own interests. . . Their present heavy workloads could be significantly lightened through more efficient organization of the health-care delivery system. . . Physicians would have more time for rest, relaxation, and continuing education. . . Increased group practice would largely release physicians from the harassment of nonmedical distractions. . . A universal health insurance system would alleviate the paper-work barrage. . .¹¹⁸

How do the British people feel about the system? A poll taken in 1963 showed that 57 percent of the people there, including almost as many Laborites as Conservatives, opposed universal and compulsory socialized medicine.¹¹⁹ These people, as reported by John Jewkes who served on Britain's Royal Commission on Remuneration of Doctors and Dentists, are "ready to make sacrifices in other directions in order to enjoy prompt hospital and specialist treatment, free choice of consultant and private accomodation."¹²⁰ Perhaps that is why private insurance has been proliferating at a fast rate for the last 15 years.¹²¹ Perhaps that

¹¹⁷Allen, p. 6.

¹¹⁸Carlova, p. 5.

¹¹⁹Allen, p. 6.

¹²⁰Ibid.

¹²¹Grasso, p. 18.

is why most Britons are ready to set aside their dreams of free medicine and switch to something better. Even as they do, the promise of Laborite Aneurin Bevan, one of the authors of the National Health Service Act, who said, "I shall stop their mouths with money," will sting in their throats.

The government of Sweden decided to wade in only waist deep, rather than neck deep, so that their National Health Insurance program, set up in 1955, pays only a part rather than all of each citizen's medical expenses, and makes payment out of separate insurance funds rather than out of general tax receipts.¹²² Swedes pay about \$14 annually in direct premiums for the program, while the remainder is subsidized by employers and general insurance revenues. The government specifies standard fees for each treatment and pays three-fourths of that fee.¹²³ Unlike the British, however, who have succeeded in controlling costs by rationing the services and using century-old hospitals, the Swedes have allowed the percentage of their GNP taken up by health care rise from 3.2 percent to 8.1 percent in the years between 1950 and 1968. In that same length of time the per capita health expenditures have increased 912 percent.¹²⁴

The U.S. News & World Report gave these observations of the Swedish system:

In Sweden, health insurance is compulsory for all. . . It replaced private, voluntary insurance that, in 1955, covered about 70 percent of the population. The present system is

¹²²Hansen, p. 4.

¹²³Ibid.

¹²⁴Grasso, p. 19.

proving anything but a clear-cut success.

The average patient here finds his situation has worsened rather than improved. It is more difficult for him to get a doctor. He must wait longer to get into a hospital. And he may be forced to leave the hospital before he is medically ready for discharge.

In Stockholm alone, some 4,000 patients are on the waiting lists for necessary operations. The situation is not much better elsewhere in the country. Some hospitals are forced to place seriously ill and dying patients in corridors and in makeshift wards. Waiting periods for special treatment are sometimes so long that patients become incurably ill, even die, before they can get adequate care. A leading Stockholm newspaper recently reported that emergency service at night was breaking down in the nation's capital. "Gravely ill patients, in need of immediate treatment, had to be turned away from hospital emergency rooms. There were not enough medical personnel on hand to take care of them."¹²⁵

Dr. Gunna Biorck, a leading administrator in Stockholm has written:

Waiting lists have been substantially increased during 1970 for admission to hospital outpatient departments (such as departments of medicine) and are so useless for admission to certain clinical departments that they are almost not in use. Two-thirds to three-fourths of all admissions to departments of medicine take place as emergencies among those who were on the waiting list. Waiting time in our outpatient department has doubled in 1971, and this is true also of other departments.¹²⁶

Swedish writer Nils Brodin also writes:

Technically speaking, medical care is good in Sweden, but it is the overcrowded conditions and the shortage of doctors and nurses which has, in effect, lowered the health standards severely. Diagnosis is often hasty and inadequate, and much time is spent in paperwork required by the state medical plan's bureaucracy.¹²⁷

. . .the increase in utilization of existing facilities comes from those who demand 'hospital vacations.' When the tensions of life or home get too intense, many will 'rest up' in a hospital. Often a patient stays in a hospital a week before he is diagnosed. . . .'I'm paying for it. . . I've got it coming' is the attitude.¹²⁸

¹²⁵Dunham, p. 2.

¹²⁶Grasso, p. 19.

¹²⁷Ibid.

¹²⁸Allen, p. 8.

It is apparent that even though Sweden's system is not as intense as Britain's, it has all the same problems. The problems lie in the system; a national health insurance program will always have the same problems as a national health service, except to a lesser degree.

The "why not, it's free" attitude has increased the average length of hospital stay in all socialized health-care countries. The average American stays 8.5 days in the hospital. The average Swede's stay is 50 percent longer, the average Briton's stay is 50 percent longer, and the average German's stay in the hospital is 300 percent longer!¹²⁹

Furthermore, socialized medicine in Sweden, like that in Britain and other countries, has also failed to keep its promise of supplying every citizen with a doctor. There are simply not enough doctors to go around; the demand is higher than the supply. The Swedish government, in order to alleviate the physician shortage, has reduced the quality of care by chopping two years off medical school curricula and filling many positions with interns and students.¹³⁰

About 15 percent of the Swedish doctors still remain in private practice, and they treat 30 percent of the Swedish patients.¹³¹ It is interesting that many Swedes would pay double (compulsory government plus private fees) simply to go to a private physician and avoid

¹²⁹Ibid., p. 10.

¹³⁰Ibid., p. 8.

¹³¹Ibid.

the government services. Part of the reason, no doubt, is the fact that Swedes are not allowed to select their own physician under the government system. Allan Brownfeld writes, "Each citizen is assigned to a government hospital where duty physicians treat everything from minor complaint to catastrophic illness."¹³² It is purely accidental if a doctor sees any patient more than once.

It is too bad that socialized medicine is failing in Sweden. In a country smaller than California, having no racial or lingual varieties, having a strong "work ethic" and a centralized population, and coming unscathed through the depleting ravages of World War II, it is saddening that the egalitarian dream does not translate into reality.

Germany has a government medical system administered by private insurance companies. The average 1951 health insurance tax was 6.1 percent of wages. Twelve years later, the same "kassen," or the government insurance bureau, took 9.6 percent of even higher wages.¹³³ Now Germans pay 11 percent of their salaries for medical care from the government; the employer pays an amount equivalent to the employee.¹³⁴

Commenting on the quality of care these taxes go to create, Donald Drake observes:

Germany has a shortage of hospital beds. . . Germany has only five heart centers capable of performing an average of 3,000 open heart operations a year when there is a need for 12,000. As a result, 9,000 patients either die or, if they have enough money, go to America and pay for the care out of their own pocket.¹³⁵

¹³²Grasso, p. 19.

¹³³Dunham, p. 3.

¹³⁴Allen, p. 7.

¹³⁵Ibid.

The average length of stay in a German hospital is 24 days, 3 times that in America; the average maternity case stays in 9 days, about twice that in America.¹³⁶ In the Munich hospitals the situation has even been more out of proportion: in the four years from 1955 to 1959 the length of stay almost doubled, from 21 days to 38 days.¹³⁷ The Germans accordingly verified the observation of the Chicago Tribune in 1959 that "the availability of state medical services seems to promote demand for them."¹³⁸

In affirmation of their confidence in receiving prompt and quality service from a system that provides comfortable vacations in bed for all, 15 percent of the German population now buy extra insurance from private corporations.¹³⁹

In France, the government pays about 80 percent of the fees of cooperating physicians. The French health insurance program was bankrupt in 1964 with a \$36 million deficit, and was \$165 million in debt in 1971.¹⁴⁰ To support this bankrupt health system the average French worker now pays 33 percent of his wages!¹⁴¹

The French system has the same maladies common to all socialized systems. But leave it up to somebody like the New York Times to turn something like overutilization into a French asset:

¹³⁶Ibid. Also see Grasso, p. 20.

¹³⁷Dunham, p. 3.

¹³⁸Ibid., p. 2.

¹³⁹Allen, p. 7.

¹⁴⁰Dunham, p. 3. Also see Allen, p. 7.

¹⁴¹Allen, p. 7.

As a result of all the advantages which the system accords, its officials have noted with rising alarm but general helplessness, there is an overwhelming eagerness among Frenchmen to take good care of themselves. . . . The doctors, the medical laboratories, and the pharmaceutical industry, both manufacturers and retailers, are prospering as the deficit grows.¹⁴²

It is interesting to note, as is shown by the above case and by the cases of Medicare and Medicaid, that it is never the system itself or the freeloaders who sponge off the system, whether patients or bureaucrats, who are blamed with the rising costs. It is always the doctors and other medical agents who are the first ones blamed.

In Japan, large scale cooperatives began to spread successfully in 1928. The rural population owned these medical facilities, which were supported by prepayment funds collected once or twice yearly. In 1942 the Japanese government made national health insurance compulsory, a move which destroyed 50% of the medical insurance carriers then in operation. Authoritarian elements were eliminated in 1948, but once again instated in 1961. Now the Japanese citizen pays 30 percent of all individual medical costs out of his pocket while simultaneously paying general taxes that go to support the rest of the system.¹⁴³

The Japanese government, at the outset of the program, had intended to "guarantee the equal treatment of all purveyors of medical care under the scheme." The result, however, was to "undermine the the zeal of the local people and insurance carriers in ensuring the the effective running of their own medical facilities and health services."¹⁴⁴ Such is the case with socialized medicine; the theoretical

¹⁴²Ibid.

¹⁴³Higuchi, p. 253.

¹⁴⁴Ibid., p. 266.

promise of citizens becoming more involved in owning and controlling their own facilities is lost in the bureaucracy, and the private capitalistic system usually does a better job of fulfilling the promises that socialism forgot to keep.

Canada's scheme is probably the most like what may come out of the U.S. system. In 1968 the program was begun and designed to be administered by the country's ten provincial governments, seven of which have now joined. A pact was made so that the private insurance companies, grouped as a single conglomerate (Healthco), could administer the plan. A variety of different plans are available, the most basic one costing \$14.75 a month that covers office calls, surgery, and various tests. An additional \$11.80 covers hospital and ambulance costs. The national government pays about 50 percent of the cost while the balance is made up by the provincial governments.¹⁴⁵

The usual reaction to all socialized systems of medicine is epitomized by Dr. John J. Alpar, who in January 1962 described his six years as a doctor in Communist Hungary:

The doctor-patient relationship is destroyed. So are the standards of medicine, since there is no hope for medical practitioners to advance in position or in finances, nor is there competition. No physician reads or tries to invent anything. The Bureaucratic red tape has stilled everything. . . . Who suffers from this system? Much more the patient than the doctor. Who likes it? Nobody.¹⁴⁶

¹⁴⁵Hansen, p. 5.

¹⁴⁶Dunham, p. 4.

DENOUEMENT

The Greek physician, Herophilus, said that illness "renders science null, art inglorious, strength effortless, wealth useless, and eloquence powerless."¹⁴⁷ He was, of course, referring to the illnesses of the human body, many of which have since been conquered or at least diminished through the great technological advancements of medical science. But what of the illnesses of the medical delivery system? Can we say that our methods of administration and delivery have likewise conquered or even diminished those ills?

On a subject so vital it is unnerving to admit that there is no simple solution to the health delivery problem. Many answers have been proposed, but no ideological health system translates very easily to the real world. It is easy to theorize about surgery until the scalpel slices your own belly; things often look quite different in a hospital bed or doctor's office than they do on paper. Our present health care system has some serious deficiencies, but the paper dream of socialized medicine also has its ugly eyesores. John Steinbeck said that "the best laid plans of mice and men often go awry," and when the production machinery of Marxian hospitals start cranking the masses through, the socialist humanitarianism which glitters so nicely on paper will melt away to reveal the skeleton of a system more devastating than anything

¹⁴⁷Hansen, p. 1.

American medicine has yet experienced. Although it is not perfect, the American system provides more and better health care to more people than in any other country. It is a virile and ever-changing system, and has always been successful in stimulating new, innovative ideas in the improvement of health care.

For example, the success of private prepaid group practices, such as the Kaiser Foundation Health Plan, in holding down costs while maintaining quality care has been phenomenal.¹⁴⁸ Blue Cross/Blue Shield has tried several experiments under the title of the Health Maintenance Plan which have also been very successful.¹⁴⁹ Certainly the American health system, pluralistic and competitive, should in its future have options such as these available to all Americans without the compulsion of a government monopoly or the destruction of the traditional fee-for-service delivery. The only major NHI bill now under consideration which encourages such diversity is H.R. 1818 and S. 218, proposed in Congress by Fulton and supported by the American Medical Association, and it is the only proposal which makes NHI voluntary. It has, like all the major NHI bills except for the Kennedy bill, some sort of patient cost-sharing (deductibles, coinsurance, or copayments) which would help prevent overutilization. But on the other hand, no family would ever have to pay more than \$2000 per year, and when this ceiling is reached, the catastrophic portion of the program takes over. And unlike the Kennedy bill, all administration is done by private insurance carriers, not by H.E.W.¹⁵⁰

¹⁴⁸ Enthoven, "Can We Control the Cost of Health Care?" p. 17.

¹⁴⁹ Buxton, Terry, "Another clinic's experience with a health maintenance plan," Medical Group Management, Vol. 21(January, 1976), pp. 28-30.

¹⁵⁰ "Comprehensive Health Care Insurance Act of 1977: Summary of H.R. 1818 and S. 218," Circular published by American Medical Association, no date.

American innovation has begun to solve other problems which socialized medicine makes a point of promising but is incapable of giving. For example, the American system has done more for getting people involved in the medical field than socialized medicine ever did. In the late 1960's, 80 health service projects were established, 50 of which were neighborhood health centers.¹⁵¹ In the health centers it was the local people who set the policies and ran the centers. Surprisingly enough, this community control went out of style in the early 1970's. Why?

(1) Budget cutbacks and the demise of the Great Society programs had made the demand seem increasingly utopian and unworkable.

(2) They never sustained mass support. "The people who would show up for a brief confrontation could not be counted on to hang in for tedious planning sessions, or for that matter, for for the next confrontation."¹⁵²

In 1971, the first Feminist Women's Health Center was established in Los Angeles by Carol Dourner and Lorraine Rothman, and since that time at least 50 women-run clinics have been set up in the United States.¹⁵³

Helen Marieskind writes:

In clinics of California women get together in groups of 6-8, learn to examine each other, share experiences, take test smears, etc. . . women who have learned skills in self-help courses were in charge. . . Instead of being a totally private and individual matter, health maintenance becomes a collective endeavor.¹⁵⁴

If this is what people are looking for, then American medicine already

¹⁵¹Riessman, Catherine Kohler, "The Use of Health Services by the Poor," Social Policy, Vol. 5(May, 1974), pp. 41-49.

¹⁵²Marieskind, p. 35.

¹⁵³Ibid.

¹⁵⁴Ibid., pp. 40-41.

has it.

The American system is also solving the problem of the doctor shortage in rural and ghetto areas, and it is doing it without shipping in foreign doctors or by chopping 2 years off medical school curricula, and it is doing it without the compulsion of socialistic punishment. Federal legislation has made financial arrangements with medical and dental students to pay the total cost of their professional education in return for practicing in underserved areas in the military or health agencies, for a specified period of time.

The Public Health Service (PHS) and National Health Service Corps (NHSC) Scholarship Training Program provide contracts offering financial assistance to students of medicine in exchange for service to the public.

The Public Health Service programs involve service in PHS operated hospitals in coastal cities, on Indian reservations, in prisons, and for the U.S. Coast Guard.

The National Health Service Corps is a program established to bring health care to areas of the country which have critical health manpower shortages. The Corps attempts to place practitioners in the medically deprived urban or rural areas in which they prefer to serve and where they may decide to stay and retain their practice after completing their obligation.¹⁵⁵

In 1976 these programs were expanded with the following considerations in mind:

On October 12, 1976, President Ford signed into law . . . the Health Professions Educational Assistance Act of 1976, more commonly known as the Health Manpower Bill. This amendment to the Public Health Service Act represents three years of Congressional effort and compromise. . .

In 1971 Congressional worries about a national shortage of

¹⁵⁵Financial Aid Handbook/1977-78, The George Washington University School of Medicine and Health Sciences Financial Aid Office(1977), pp. 36-37.

doctors prompted the provision of basic federal grants to medical schools. By 1974, when most of the provisions of the 1971 Act had expired, health manpower experts had become more concerned with the geographic and specialty maldistribution of physicians than with the overall physician supply. Data pointed to the need for primary care doctors in underserved rural and urban ghetto areas.

A number of alternatives were put forward in 1974 and 1975 as remedies for the doctor distribution problems. In 1975, for example, the House agreed to a provision which would have required all medical students to repay the federal government "capitation" grants paid on their behalf to medical schools if they did not practice in a doctor shortage area for a specified time period after graduation. A Senate version, passed in July of 1976, would have cut off capitation support to medical schools that did not reserve an increasing number of residency positions for students accepting scholarships which required them to serve in an underserved area.

House-Senate conferees found these student "payback" and scholarship "quota" proposals too drastic. Instead, they agreed to increase the funding for scholarships requiring a service obligation believing that more students would seek scholarships voluntarily if the program were expanded.¹⁵⁶

Gary Allen has suggested an additional solution to the doctor shortage problem:

The shortage of doctors in "ghetto" areas might be greatly alleviated without government compulsion if the foundations and such organizations as the N.A.A.C.P. and Urban League would stop playing revolutionary games long enough to run campaigns recruiting young physicians to practise in Negro neighborhoods and rural areas, meanwhile offering scholarships and loans and special preparatory training to qualified Negroes seeking to become medical students.¹⁵⁷

Many loan and scholarship programs are opening up to minority and underprivileged students that will allow them to attend medical school and return to practice in underserved areas: The Robert Wood Foundation, National Medical Fellowships, Inc., Indian Health Employees Scholarship Fund, Martin Luther King Jr. Fellowships,

¹⁵⁶Ibid., p. 13.

¹⁵⁷Allen, p. 12.

and many others.¹⁵⁸ Another suggestion is presented by the American Dental Association: "Dentists should be encouraged to practice in underserved areas through federal financial incentives including guaranteed loans and tax benefits."¹⁵⁹ Clearly all of these ideas, and many others, could be useful in solving the physician maldistribution problem.

All of our traditional problems, in fact, can be solved with traditional methods; the American system of free enterprise has done too much good to be abandoned for the dream of a system which has failed wherever it has been tried. The formation of a comprehensive national health insurance program or a national health service would do nothing except add the eyesores of socialized medicine. Yet in the face of all these socialized medical failures, in the face of all the accomplishments of American medicine, in the face of so many different avenues of future recourse, people are still turning to socialized medicine.

Why? To stem health care costs? But it will not; the government health-care programs of the U.S. and the systems of Europe prove it. To give every citizen a doctor? But it has not, nor can it, unless it uses the point of a government gun. To increase community participation in medical care? But it will not, as the recipients in Japan and England can attest. To make health care a right for everyone? But it cannot; European hospital waiting lines and huge government deficits are proof. To improve the quality of

¹⁵⁸Financial Aid Handbook/1977-78, pp. 49-51.

¹⁵⁹Guidelines for Dentistry's Position in a National Health Program, Circular published by the American Dental Association, no date, p. 4.

health care? It will not, it has not, nor can it; political plans that promise redemption for the masses easily lose sight of the person for the sake of the program, and socialized medicine is the paramount example. Writes Harry Schwartz:

The American Medical system--pluralistic, complex, and ever-changing--has served the American people well. It can continue to do so if the aim of change is to increase the choices of both health care providers and those who need their help. Those who would collectivize American medicine to satisfy their ideological preferences would have cause to regret the result when they themselves required medical care for serious illness.¹⁶⁰

There is no perfect health system, and as long as men and women are imperfect there never will be. There are problems, but there will always be problems. There is no pat answer, no snappy solution, and there probably never will be.

But we have the methods; we have the innovative capability to solve them, and we can do it under the American health care system. We can do it without compulsion, and we can do it while preserving the creativity of the doctors and the autonomy of the patients. When the knife of tragedy slices our own bellies, we will know, at least, that it is a strong and virile hand, not a weak and fleeting dream, which grasps to stay the blade.

¹⁶⁰Grasso, p. 22.

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