HOW to finance our nation's medical bill has been a subject of hot debate for the past twenty years. Today the issue has become much narrower than it appeared to be only a few years ago. From Senator Taft of Ohio to Senator Taylor of Idaho, there is now agreement that some form of government aid is needed in wide areas to maintain and improve the nation's health. Medical services for the veterans, financial assistance for the construction of hospitals, grants in aid to medical schools, expansion of public health services are no longer subjects of controversy. The practice of group medicine is no longer opposed by the medical profession, and even the principle of health insurance is now universally accepted.

The controversy has now narrowed down to one single issue: Should health insurance be sponsored by the government and the extent of its coverage determined by law, or should it be voluntary and left entirely to the free choice of the individual?

If the American people are to make an intelligent choice between these alternatives, two obstacles must be removed which now obscure from the view of the general public the true merits of the case on either side.

The first of these obstacles are the propaganda slogans. This is not the life and death struggle between socialism and free enterprise as it is being depicted by the American Medical Association and its allies.
Nobody would call our public schools "socialist" because they are owned and operated by units of government; and our home building industry certainly continues to regard itself as "private enterprise" even though a large segment of its operations is dependent upon the mortgage guarantees of the federal government. The tags of "socialism" and "free enterprise", in this as in other fields, serve only to confuse instead of to identify the issues.

Public Should Be Heard

The second obstacle is the failure of the general public to participate in this debate. Voluntary vs. government insurance is not a medical issue. On how to practice medicine, nobody is qualified to speak but the medical expert; but how to pay for medical services is as much, if not more, the concern of the consumer of these services—99.9% of our population—as it is that of the 150,000 physicians engaged in the private practice of medicine. To select the best system of health insurance calls for the special knowledge of the economist, the tax expert, the student of government and public administration, the actuary. The voice of the American Medical Association should not carry any more weight in this debate than that of the United Automobile Workers or the American Association of Social Workers.

What, then, are the facts? What is proposed by the advocates of national health insurance? What is offered by the existing voluntary plans?

Following President Truman's special message on the nation's health, the National Health Insurance and Public Health Act was introduced into Congress in April 1949. Title VII of this Act proposes to expand the social security system by adding health insurance to the existing old age, survivors' and unemployment insurance. The bill proposes to cover approximately 85% of the population including both employees and self-employed persons, and their dependents. Persons covered by insurance would be entitled to medical services by general practitioners and specialists at their homes, in the doctor's office, and in hospitals; to hospital care up to 60 days per year; to laboratory and x-ray services, costly prescribed medicines, eyeglasses, special appliances, and certain amounts of dental services and home nursing. Patients would be free to select the doctor, dentist, and hospital of their own choice; doctors, dentists, and hospitals would be free to join or not to join the insurance system and to accept or reject individual patients. The program would be administered by the states and their subdivisions (counties and municipalities). Administration at the local level would be put into the hands of local boards appointed in accordance with state law and composed of local citizens, including members of the medical profession. The role of the federal government would be limited to the collection of the health insurance fund for distribution to the states. A federal board composed of five persons would establish certain general requirements with which state programs would have to conform. Doctors would be paid from the health insurance fund on a fee-for-service, capitation, or salary basis, depending on what system of payment the participating doctors in each locality would choose for themselves. The program would be financed by a special tax of 3% on all incomes up to $4800 a year. Self-employed persons would pay the full amount themselves; employees would pay 1 1/2% themselves, and the other 1 1/2% would be paid by their employers.

A large number of voluntary health insurance plans are now in existence. For purposes of comparison, the combined Blue Cross—Blue Shield Plan of the Associated Hospital Service of Philadelphia and the Medical Service Association of Pennsylvania is used as a typical example of the best that voluntary health insurance has to offer.

Maximum benefits under the Blue Cross plan include 30 days of hospitalization for each different ailment requiring admission to a hospital in any one year. Hospital service is provided in the lowest cost semi-private room available at the time of admission; it includes all services rendered by salaried employees of the hospital and all drugs in general use. X-ray examination, laboratory examination, etc., are limited to certain maximum amounts. Hospital care for patients suffering from pulmonary tuber-
culosis or mental or nervous disorders is limited to ten days. Conditions existing prior to enrollment are not covered during the first twelve months. Maternity benefits are provided up to $75 a year after the subscriber has been enrolled for twelve months.

The medical-surgical plan of the Blue Shield provides surgical services up to $200 a year according to the Blue Shield Schedule of Surgical Payments regardless of whether the surgical operation is performed at home, at the doctor's office, or in a hospital. Medical services are paid hospitalized patients up to 70 days at the rate of $10 for the first, $5 for the second, and $3 for the remaining days. Medical service at the patient's home or the doctor's office are covered up to 21 visits at $3 per visit starting with the fourth visit, if the subscriber is a member of an affiliated employee group and is disabled by illness. Medical treatment for mental, TB, and VD cases is limited to 30 days in a hospital.

Doctors participating in the Blue Shield Plan are allowed to make additional charges over and above those paid for by Blue Shield if the annual income of a subscriber with two or more dependents is more than $4,000.

The cost of this combined Blue Cross-Blue Shield plan for a family including husband, wife, and all unmarried children under 19 years of age is $6.10 a month or $73.20 a year.

Disregarding differences in benefits, which will be discussed later, a comparison of the costs of health insurance under the two plans for three different levels of income is shown by the table at the bottom of this page.

No comparison is possible for incomes over $4000 a year because Blue Shield permits doctors to charge unspecified additional amounts.

As far as benefits are concerned, these are some of the major differences between the two plans:

Blue Cross provides for hospitalization for 30 days for any one ailment; National Health Insurance for 60 days per year. Hospital care for TB or mental patients is limited by Blue Cross to ten days. Maternity benefits, x-ray examinations, and laboratory examinations are limited by Blue Cross-Blue Shield to hospitalized patients and to certain maximum amounts; they are not limited under National Health Insurance.

Blue Shield does not cover any medical services unless the subscriber is disabled by illness (i.e. required to stay home from work) and does not cover the first three visits at the patient's home or the doctor's office even though the subscriber cannot go to work.

This is probably the most serious shortcoming of the voluntary plans. If the old adage, "An ounce of prevention is worth a pound of cure" has any validity, voluntary health insurance as offered today contributes nothing to that part of our total medical bill that is most vital from the standpoint of the nation's health; the cost of preventive medicine. Voluntary insurance as offered today is sickness insurance and not health insurance.

More serious than the gaps in the coverage provided by voluntary plans to the individual subscriber is the failure of these plans to enroll, at least so far, enough subscribers to justify their claim that they can do the whole job. According to the AMA's own figures, only 13 million people or less than 9% of the total population have comprehensive Blue Cross (hospitalization)—Blue Shield (medical-surgical) or similar cover-

<table>
<thead>
<tr>
<th>Annual Income</th>
<th>Blue Cross-Blue Shield Plan</th>
<th>National Health Insurance</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Amount % of income</td>
<td>Employed Amount % of income</td>
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<tr>
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<td>$60.00 1.5</td>
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July, 1950
An additional 21 million have hospitalization and surgical coverage, and 27 million have only Blue Cross (hospitalization) coverage. (At the end of 1949 only 5% of the population of Pennsylvania were Blue Shield members).

Moreover, present subscribers are very unevenly distributed geographically and economically. In May, 1949, about 60% of all Blue Cross policies were held by citizens of six rich industrial states of the East and Midwest. Only 17% of Blue Cross members lived in Southern and Western States with 43% of the population. Only 3% of the rural population were covered.

The members of voluntary insurance plans are the industrial and clerical employees in the East and Mid-West. A large share of the credit for enrolling so many of them in recent years belongs to the trade unions which have won health insurance benefits through collective bargaining. At the same time, the advances gained by union members in this field are threatening to disturb the competitive equilibrium between the various parts of our economy in the same way in which it has been disturbed by wage differentials in the past and more recently by the spread of private pension funds. If this trend continues, we may some day see the National Association of Manufacturers and the U. S. Chamber of Commerce retreat from their position against national health insurance just as they have retreated recently from their former opposition against the broadening of social security.

It would be highly desirable if the American people—all of them—could be induced to insure themselves voluntarily against the cost of medical care; but is it realistic to assume that this ideal can ever be reached? Americans have an innate desire to pay for what they get. They despise "charity." That is why any system based on the "means test" will never become law. That is why people risk sickness rather than being "charity patients." Are we not expecting too much if we assume that the head of a family who can barely stretch his pay check to cover the cost of food, clothing, and shelter would part voluntarily with $6 a month for health insurance? That "the spirit is willing but the flesh is weak" is clearly demonstrated by the fact that the American people spend each year more money for liquor, for entertainment, and for other luxuries than they spend for medical care. Is it really "socialistic and communist" to help the spirit along by using the democratic process of legislation to give the nation's health priority over other less vital needs?

Resistance against anything that bears the label of "compulsion" is one of the strongest—and healthiest—traits in our national character. Opponents of national health insurance have used the compulsory feature of the plan as one of the most effective weapons to whip up sentiment against this piece of legislation. Yet compulsion is the very essence of every law imposed on the individual by the community—from the traffic ordinance to the Constitution of the United States. Once it is admitted, as proponents and opponents of the program do, that health is a matter of legitimate national concern, compulsion becomes as appropriate in this field as in the fields of civil rights, education, social security, or the protection of life and property of the individual and the community at home and abroad.

In April, 1934, at a time when the American Medical Association was fighting voluntary health insurance as "Socialism and Communism inciting to revolution," it issued the following statement:

"Without some form of compulsion voluntary insurance fails of its objective of distributing the cost of sickness among large classes of the population with even approximate fairness. The young and healthy will not join and the aged and sickly, if accepted, will raise the cost to a prohibitive point and, if rejected, remove protection from those most in need. Sickness insurance cannot distribute the burden of sickness unless it is compulsory."

We might well rest our case for national health insurance on this statement.