MEDICAL CARE —OLD GOALS and NEW HORIZONS

By

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THE SPEAKER

DR. GEORGE BAEHR has achieved eminence as a physician, one of the nation's outstanding clinicians; as a pioneer in the development of more effective and lower cost patterns of distribution of health services; and as a public servant in the field of health. Dr. Baehr obtained his medical degree from Columbia University in 1908 and studied subsequently in Freiburg and Vienna. He has been a member of the Public Health Council of the State of New York since 1935, chairman since 1955. In the early 1930's he became interested in the possibilities of group practice and was instrumental in forming the Health Insurance Plan of Greater New York. He served with distinction in two world wars—as commander of a base hospital in France in World War I, and as Medical Director of the U.S. Public Health Service and Chief Medical Officer of the U.S. Office of Civilian Defense in World War II. He is a member of the Board of Hospitals of the City of New York and Chairman of its Hospital Code Committee; a Director of the Milbank Memorial Fund; a Trustee of the Community Service Society; a member of the Board of Managers of the State Charities Aid Association; and a member of the Society of Medical Administrators. He has been Director of Clinical Research at Mount Sinai Hospital and is the hospital's Director Emeritus of Medicine. He was Clinical Professor of Medicine at Columbia University; President of the New York Academy of Medicine; President and Medical Director of the Health Insurance Plan of Greater New York; and Vice-President of the American Public Health Association. He is co-author of *Cecil's Textbook of Medicine*, 8th ed., 1952; co-editor of *Convalescent Care*, 1940; *Preventive Medicine*, 1942; *Medical Uses of Cortisone*, 1954; *Oxford Loose-Leaf Medicine*, Vol. IV, 1955.

THE SERIES

The lecture series was established in the name of Dr. Michael M. Davis, medical care pioneer, by his friends and admirers. Each year a distinguished authority is invited to address those interested in the improvement of medical services, to stimulate free and open discussion in a forum where medical care programs may be proposed, examined, and presented for public consideration.

THE OCCASION

DR. BAEHR delivered this talk at Billings Hospital, the University of Chicago, on May 13, 1965.

"MEDICAL CARE for the American People," the majority report of the Committee on the Costs of Medical Care, was published in 1932 under the imprint of the University of Chicago Press. It represented the labors over a period of five years (1928–32) of 50 leaders in the fields of medical practice, public health, the social sciences, and the public, aided by an expert research staff. It had been preceded by publication of 26 fact-finding studies by the staff of the Committee. The financial support was provided privately by eight philanthropic foundations. The chairman of the Committee was Dr. Ray Lyman Wilbur, a past president of the American Medical Association and former Secretary of the Interior. Dr. Michael M. Davis served on the Committee as a representative of the social sciences. During the past 33 years he has, in my opinion, done more than anyone in this country to promote the improvement of medical care for the American people in accordance with the findings and recommendations of the Committee.

This lectureship was established by his admirers in recognition of his outstanding public services. It seems therefore appropriate to devote the third Michael M. Davis lecture to a review of what has and what has not been accomplished by American medicine and by the American people in carrying out the recommendations of the Committee. It is my hope that we may thereby gain a perspective both of our accomplishments and, more important, of our failures. It is especially important that we recognize those influences that have during these many years retarded progress in improving the organization of medical services, despite the fact that such services have become increasingly complex and costly as the Committee had anticipated.

I begin by recalling the three major recommendations of the Committee:

1) That medical services, both preventive and therapeutic, should be furnished largely by organized groups of physicians, dentists, nurses, pharmacists, and other associated personnel, organized preferably around a hospital, for rendering complete home, office, and hospital care;
2) That the costs of medical care be placed on a group prepayment basis through the use of insurance, through the use of taxation, or through the use of both of these methods;
3) That the study, evaluation, and coordination of medical services be considered important functions of every state and local community; that agencies be formed to exercise these functions; and that coordination of rural and urban services receive special attention.

The other two recommendations of the Committee relate to the extension of public health services and to professional education.

Seventeen years after the publication of the Committee's report, the President of these United States appointed a Commission on the Health Needs of the Nation to reexamine the problem. It covered the same ground and arrived at virtually identical findings and recommendations.

In 1944, because of inaction, the New York Academy of Medicine appointed an independent committee of physicians and distinguished lay community leaders to restudy the problem. After laboring conscientiously for three years and again issuing a series of fact-finding publications, the final report of the Academy's Committee on Medicine in the Changing Order (1947) endorsed group prepayment for comprehensive medical care provided by medical group practice.

In each of these independent studies, the proponents anticipated that the American genius for

organizing the variety of skills and services characteristic of American industry, which had made this country the leading industrial nation of the world, could be and would be mobilized in organizing the equally complex health services required in these times. It was hoped that the health professions, aided by government, would recognize the need for assembling the rapidly multiplying scientific skills and services involved in ambulatory, domiciliary, as well as in-hospital medical care into efficient and humane service units which would elevate the general quality of medical care throughout the nation and, at the same time, eliminate unnecessary duplication of wasteful facilities and services under our present system of solo practice. By this means the rising costs of medical care might be stabilized at least within predictable limits, and medical care become comprehensibly insurable so that families could budget the costs of personal health services as they do food, shelter, and other basic necessities of life.

This vision of the future has thus far proved to be a mirage, except for some programs of organized prepaid comprehensive medical care in scattered areas of the country. Although voluntary health insurance has indeed prospered and is now being sold to over 145,000,000 persons by more than 1,800 individual insurance carriers, their fee-for-service indemnity payments do not defray more than 30 per cent of the total cost of family medical care, if one includes the costs of hospitalization, physicians' and dentists' services, drugs and medical appliances, nursing and other paramedical services required for the care of the sick and the prevention of illness. After 33 years, comprehensive coverage for the costs of medical care still remains largely uninsurable for the simple reason that the predominant pattern of private medical practice continues to be solo practice on a fee-for-service basis as it was 100 years ago.

FACTORS INFLUENCING THE RISING COSTS OF COMMUNITY MEDICAL CARE

Hospital administrators ascribe the rising costs of hospital and medical care during the past three decades to two major factors: 1) rising wage scales for professional and non-professional health personnel; and 2) advances in the medical sciences which require more costly facilities and services. The anxieties of the public concerning rapidly climbing costs are being tranquilized for the time being by this explanation which embodies only half the truth.

The wage scales of health service personnel and the number of new scientific procedures have risen rapidly. Hospital costs have been increasing progressively at the rate of 7 to 10 per cent each year and under our prevailing systems of medical and hospital practice no end to the rapidly-rising costs is foreseeable. But this calls more urgently than ever before for the elimination of unnecessary duplication and of sinful waste in the existing misuse of medical care facilities and services. The recommendations of the CCMC have become even more pertinent today than they were 33 years ago.

The public is generally unaware of the inflationary influence of the existing pattern of solo private practice and the traditional method of remunerating physicians by fees for each service upon the costs of domiciliary and hospital care. As the Committee foresaw, and as subsequent experience has amply confirmed, rising costs can be controlled in large measure and at the same time the quality of medical care can be safeguarded by effective organization of all personal health services, by the attachment of such extramural health service groups to good hospitals, and by the regional alignment of hospitals with one another.

Today, after more than three decades, only about 4,000,000 people out of over 190,000,000 are as yet receiving prepaid medical care of comprehensive scope from organized medical care groups. Almost half of the 4,000,000 are enrolled in two large organizations, the Kaiser Permanente Plan on the West Coast and the Health Insurance Plan of Greater New York (HIP). The remainder are enrolled in smaller group-practice units in various localities throughout the country, sponsored by an industrial organization for its own employees, or by a labor union for its members, or by an industrial or farm cooperative, or by a group of physicians. Three major plans sponsored by a community are the HIP of New York; CHA, the Community Health Association of Detroit; and GHA, Group Health Association of Washington, D.C. Although community-sponsored, the initial impetus in the case of HIP was the local city government; in the case of CHA, the United Automobile Workers of America; and in the case of GHA of Washington, D.C., a group of federal employees.

The recorded experience of these organized comprehensive health service plans has amply confirmed the predictions of the CCMC and of the President's Commission on Health Needs of the Nation. Because of their organizational structure and capitation method of prepayment for medical care, they have demonstrated their ability to provide insured families with comprehensive medical services of uniformly high quality, preventive and therapeutic, and, at the same time, keep rising costs of family medical care within reasonable limits.

They have also made an important demonstration which had not been anticipated by the CCMC; namely, that the availability to an in-

sured population of the unlimited services of family physicians, pediatricians, and all the required specialists, as well as laboratory, X-ray, and other ancillary facilities on an ambulatory basis, substantially reduces the need for the use of costly hospital beds. In a hospital utilization study made in 1955, the annual hospital admission rate to short-term general hospitals of the 7 million Blue Cross subscribers in the New York City area was 96 per 1,000 enrollees; the number of days of hospital confinement averaged 688 days per 1,000 insured persons. In contrast to this area-wide experience, the 650,000 Blue Cross subscribers who receive comprehensive prepaid medical care from 31 HIP medical groups in their homes, doctors' offices, and medical group centers had an annual hospital admission rate of only 77 per 1,000 enrollees, and they averaged only 588 days in hospitals per 1,000 enrollees. More recent data (1962) reveal that the HIP rate of hospitalization has remained consistently at this same low level year after year.

An independent study of the experience of three labor unions in the New York area made by the Health Information Foundation confirmed these findings. Members of these unions had been given a choice between two kinds of comprehensive health insurance coverage for physicians' services outside of as well as in hospitals. One plan (GHI) paid individual physicians of the patients' choice on a fee-for-service basis; the other (HIP) provided services through 31 medical groups prepaid monthly by a capitation payment for each person enrolled in the group for continuing medical care. Under the fee-for-service system of paying individual physicians (GHI), the annual hospital admission rate was found by HIF to be 110 per 1,000 enrollees and the average number of days in hospitals was 870 per 1,000

enrollees; among persons receiving comprehensive medical care under the prepaid group practice plan (HIP), the annual hospital admission rate was 63 per 1,000 enrollees and the days in hospitals averaged only 410 per 1,000.

A similar study was made by Professor I. S. Falk of Yale of members of the United Steelworkers of America and their families insured for medical care by individual physicians of their selection under fee-for-service indemnity plans compared with the hospital experience of those who enjoyed prepaid comprehensive medical care from the Kaiser Foundation's medical groups on the West Coast. The annual hospital admission rate of those receiving comprehensive medical care under the organized group-practice plans was 90 per 1,000 persons whereas the hospital admission rate of steelworkers enrolled in fee-for-service indemnity plans was 135 per 1,000. Those who received comprehensive medical care outside of as well as in hospitals from group-practice teams averaged only 570 days in hospitals per 1,000 enrollees per year (a rate similar to that of the HIP enrollees) whereas 1,032 days were spent in hospitals by the steelworkers and their dependents covered by the Blue Cross–Blue Shield fee-for-service indemnity plans, and 1,167 days per 1,000 of those insured by commercial insurance companies under indemnity contracts.

A study by Josephine Williams which failed to find a difference in hospital utilization in three contrasting settings—Blue Cross–Blue Shield of New Jersey, Major Medical of General Electric, and the Kaiser Permanente Plan—was based on small samples in widely scattered geographic areas. As the only recorded exception, it contrasts with the enormous countrywide experience of a federal employee program, described below.

In October 1964, George S. Perrott reported to

the Medical Care Section of the American Public Health Association on three years of experience of the Federal Employees Health Benefits Program. Under the federal program, $6\frac{3}{4}$ million individuals were covered on June 30, 1964, for prepaid medical care either under a low-option or a high-option plan; 85 per cent chose the high-option benefits.

Under the high-option plans, the Blue Cross–Blue Shield annual hospital admission rate during the program's first two years was 104 per 1,000 insured persons and the average time spent annually in hospitals was 882 days per 1,000. In sharp contrast, the population which received medical care during the same two-year period from prepaid group-practice plans in various parts of the continental United States had an average annual hospital admission rate of 58 per 1,000 persons covered and the annual average length of stay in hospitals was only 460 days per 1,000 persons. In the New York area, the experience of federal employees who enrolled in HIP medical groups for their medical care was virtually identical with the national figures of all group-practice plans—an annual admission rate of 58 per 1,000 and an average of 445 days in hospitals.

During the third year (1962–1963), the hospital utilization experience of the federal program was about the same as during the first two years: Blue Cross–Blue Shield enrollees averaged 865 days in hospitals per 1,000 persons covered; the group-practice plans nationally averaged 433 days; and HIP in New York averaged 435 days per 1,000.

The difference of close to 50 per cent in the utilization of hospital facilities under the two systems of medical care and payment for physicians' services may perhaps be ascribed in part to the number of surgical operations performed annually on federal employees and their families

under the two different systems of medical care:

NUMBER OF SURGICAL OPERATIONS PERFORMED

	Per 1,000 Persons
All Surgical Procedures	
Under Blue Cross–Blue Shield Plans	70.0
Under Group-Practice Plans	39.0
Tonsillectomies and Adenoidectomies	
Under Blue Cross–Blue Shield Plans	10.6
Under Group-Practice Plans	4.0
Female Surgery (excluding D&C)	
Under Blue Cross–Blue Shield Plans	8.2
Under Group-Practice Plans	5.4
Appendectomies	
Under Blue Cross–Blue Shield Plans	2.6
Under Group-Practice Plans	1.4

So great a difference in hospital utilization under the two systems of medical care and methods of payment upon the costs of medical care must undoubtedly be an important factor in the magnitude of personal consumer expenditures in the United States for *private* medical care, which in 1963 reached 23.7 billion dollars. The ratio of personal expenditures for medical care to total personal consumption expenditures by the American people increased from 4.3 per cent in 1948 to 6.3 per cent in 1963. Of this sum, 29.2 per cent represents hospital costs, 27.9 per cent physicians' charges, and 26.5 per cent drugs and appliances used for the care of the sick (19.9% for drugs and 6.6% for appliances). In New York City private citizens spend about $1 billion a year for personal health services through insurance and direct out-of-pocket payments and an additional $750 million a year is spent by the state and local governments for the health and medical care of residents of the city of all economic levels.

THE ATTITUDE OF HOSPITALS

In spite of the mounting public anxiety concerning the rapidly rising costs of hospital care and of Blue Cross insurance rates, these observations concerning the influence of the type of medical care insurance upon hospital utilization have received little attention from the public, and the governing bodies of voluntary hospitals, or from Blue Cross executives. I believe this attitude is not due to ignorance or indifference but rather to a silent consensus that the present climate of affluence which characterizes private medical practice in our country makes it difficult to change the existing order. The prevailing conditions of solo medical practice and fee-for-service indemnity insurance which encourage unnecessary and wasteful hospital use and rising community costs for hospital and medical care may therefore be expected to continue until the situation becomes more critical.

Meanwhile, temporizing methods of curbing over-utilization are being tried by some hospitals, such as the appointment of hospital utilization committees of medical staff members. This back-door approach to the problem sometimes has had a transitory effect in a few institutions, but it has not had any appreciable effect on the annual rate of hospital usage throughout the country, which has continued to rise year after year and by 1963 had reached 135 admissions per 1,000 persons.

At the instigation of the Blue Cross plans, Hospital Review and Planning Councils in several states are now endeavoring to persuade state and local governmental authorities to deny approval for the construction of any additional hospital beds so that the number in their area may be kept to an irreducible minimum, and thereby "put the squeeze" on the medical profession. The existence of an excessive number of hospital beds in a community unquestionably encourages over-utilization. On the other hand, if controls are carried too far in an effort to keep down Blue Cross insurance rates through the device of bed scarcity, a serious public health hazard may be created. This possibility was emphasized in the report of a study of British hospitals by M. S. Fieldstein published in a recent issue of the *British Medical Journal.*

A recent amendment to the Hill-Burton Act will hereafter place more emphasis on federal aid for the replacement of obsolete urban hospitals rather than on the creation of additional beds in urban areas. This is a move in the right direction, but there is a possibility that such federal grants may be used with the passive acquiescence of local advisory hospital councils to rebuild venerable but unnecessary hospitals, and thereby perpetuate existing duplication. It will take more courage than is usually found in most local hospital councils for them to rule that an unnecessary hospital, especially one sponsored by a religious order, should cease to exist or should merge with a better hospital.

In the second annual Michael M. Davis Lecture, Marion Folsom laid stress on the need for the regional realignment of hospital facilities in order to eliminate duplication, reduce unnecessary community costs, and improve the overall quality of hospital care in the area. There is no disagreement among hospital authorities about the desirability of regional hospital planning and their functional coordination; yet thus far there have been few instances of effective nationwide regionalization comparable to the achievement in the Rochester, New York, area under Mr. Folsom's influence.

The urgent need for community action is revealed by the following data concerning 5,684 non-federal short-term general hospitals published in Part 2 of the 1964 Guide Issue of *Hospitals:*

1. The average hospital cost per patient day throughout the United States increased 314 per

cent between 1946 and 1963 and now averages about $40 a day. In some urban institutions the average cost has reached $50 to $60 a day. Based on the recent experience of 96 general hospitals in the New York Metropolitan Area, the Hospital Review and Planning Council of Southern New York predicts that hospital costs will rise at least another 35 per cent during the next five years.

2. In 1946 all registered hospitals (short-term and long-term) spent $1.1 billion for wages out of a total operating budget of $2.0 billion (about 55 per cent); in 1963 they spent $7.3 billion for wages out of a total budget of $11.0 billion. Hospitals now spend two-thirds of their entire operating budget for wages. In some the ratio is even higher.

The Public Health Service finds that per-diem hospital expenses increased in this country between the years 1946 and 1961 by 273 per cent, during which period the Consumer Price Index rose 53 per cent. The rise in the general price level accounted therefore for less than one-fifth of the rise in hospital costs per patient day.

As the costs of hospital care have mounted, nonprofit voluntary hospitals have steadily increased the relative percentage of private beds so as to derive more income from private patients and insurance carriers. The decline in ward beds previously occupied by the medically indigent is therefore placing an ever-increasing burden on the tax-supported hospitals. In a recent review of Metropolitan Medical Economics in the January 1965 issue of *Scientific American*, N. K. Piore reported that outlays from tax funds now account for nearly one-third of the total bill for all personal health services rendered to 2.8 million families in New York City, and for more than half of the cost of care received by New Yorkers as inpatients in hospitals and related institutions. More than a third of all adults hospitalized for short stays are in municipal hospitals or are city-charge

patients in voluntary hospitals. Public expenditures for medical care for New York City rose from $530 million in 1961 to $734 million in 1964, a 38 per cent increase in three years. Seventy-two per cent of the population of the city have some form of hospital insurance, yet the pressure on the city's hospital system has in no way diminished.

Forty-four per cent of all babies born in the city each year are now delivered in municipal hospitals or in the wards of voluntary hospitals. Three out of seven deliveries in the city are paid for by the city. Well over a third of the children in the city do not receive systematic medical supervision from private practitioners. Under our prevailing system of medical practice, 13,000 preventable deaths a year are due to the conditions under which one-fifth of the population lives.

INFLUENCE OF THE STRUCTURAL LAYOUT OF HOSPITALS

In any competitive industry, management would take a hard look at such figures and investigate whether the high level of expenditures for wages, which affects the cost and marketability of the product in a competitive situation, might perhaps be due in part to the use of an obsolete and inefficient structural layout which requires the employment of an excessive number of workers. Most of our hospitals were built in the days when wages were only a fraction of what they are today. Therefore, wages as a factor in the operating expense of large hospitals received scant consideration when the institutions were built. In subsequent expansion of hospitals it has usually been the custom to erect additional buildings and ignore completely the number of employees who must be in motion between them and the effect of such wasteful labor costs upon the hospitals' operating budget. To this very day new hospitals are still being erected in this multi-building pattern,

in spite of the fact that wages now average two-thirds of a hospital's operating costs.

A recent study by the architectural consultant, Joseph Blumenkranz, of a large municipal hospital with 16 separate buildings and of a voluntary hospital with 22 separate buildings demonstrated the extraordinary number of miles traversed daily by hospital employees and by the staffs of these hospitals in their perpetual peregrinations from one building to another. An enormous amount of their time is also lost in waiting for elevators in each of these buildings. It was estimated that several million dollars a year could be saved in labor cost in each of these institutions if the complex of many structures was replaced by a single multi-storied building which would permit the use of banks of vertical automatic elevators and other modern forms of mechanical automation and thereby eliminate 90 per cent of the lost motion. The predictable savings in wages from space-saving vertical design, automation, and similar mechanical efficiencies are so enormous that the major costs of new construction could be largely capitalized in future years from resulting labor and other operating economies.

Most hospital administrators have not been concerned with these matters but rather with keeping all existing beds filled with paying patients. They are rarely troubled about the effect of their hospital's operational costs on the financial burden for medical care which must be carried by the total community. The frequently-recited slogan of many hospital administrators, that "an empty bed is a costly bed," is true as far as the hospital's own income is concerned. But the needless occupancy of hospital beds magnifies the costs which must be met by the patients, by insurance carriers, and by the community at large.

OTHER FACTORS WHICH MAGNIFY COSTS

The prevailing indifference of hospital administrators and attending physicians to community costs was strikingly emphasized in a recent study, by Frank van Dyke and his associates of the Columbia University School of Public Health and Administrative Medicine, of long-term stay patients in the wards of short-term general hospitals for whom the City of New York pays the major share of the hospital bill. The study involved the examination of 611 ward patients who had been hospitalized for 30 days or longer in five voluntary and four municipal hospitals. Well-qualified specialists served as impartial investigators. They found that 40.6 per cent no longer required the services of a short-term general hospital at an average cost of more than $40 a day. Among patients 65 years of age or older, who comprised a third of the total number, 50 per cent did not need to be in the hospital. In the five voluntary hospitals misuse of hospital beds for unnecessarily prolonged stay was generally less than in the municipal hospitals; it varied between 15 and 59 per cent.

Another source of waste in the use of hospital facilities is the traditional five or five-and-a-half day week. Studies by Ray Trussell and his staff have revealed that private patients admitted to hospitals on a Friday tend to average two more days in hospitals than those admitted on a Tuesday. Although the average per-diem cost to the hospital is less when the operating rooms, laboratories, physical therapy, and other diagnostic and therapeutic facilities lie idle over the weekend, the ultimate cost to the patient, to Blue Cross or other insurance carriers, and to the community at large is unquestionably much greater than if these facilities were in full use every day of the week and the average patient stay thereby reduced by several days. Also, fewer hospital beds and fewer hospitals would be needed. Some operational and

staffing problems would be encountered if hospitals functioned actively seven days a week, but a more competitive industry or quasi-public utility would not find such difficulties insurmountable.

Another more easily correctable source of financial waste is to be found in the laboratory operations of hospitals. Complex and costly laboratory procedures have multiplied enormously in recent years. Their cost could be greatly reduced, the general level of scientific accuracy improved, and their reporting expedited if hospitals in large communities would organize and use a central laboratory for the more complicated and costly chemical, physical, and biological procedures. New labor-saving devices such as auto-analyzers, micro-auto-analyzers, and other modern electronic devices permit the simultaneous performance of hundreds of chemical and biological analyses at greatly reduced cost per test and with greater accuracy and speed. Few hospitals have the volume to justify the installation of such mass techniques for their individual use.

As Americans we take justifiable pride in our many excellent hospitals, but from these few illustrations it would seem that "all is not right in the State of Denmark!"

THE QUALITY OF COMMUNITY MEDICAL CARE

It seemed self-evident to the CCMC that medical services provided by family physicians and pediatricians who are members of a well-organized medical group, and who have at their disposal a complete roster of qualified specialists, laboratory and X-ray services, paramedical facilities, visiting nurses, and social services would tend to elevate the general quality of community medical care. Yet, in spite of the favorable findings of the Larson Committee's investigation of prepaid group practice made for the AMA, this has been

questioned by county medical societies, most of whose members are single-mindedly dedicated to the perpetuation of solo practice and the preservation of the fee-for-service principle of payment. There is now sufficient experience with prepaid comprehensive group practice to warrant an objective decision on this question of quality.

The 31 HIP medical groups in the New York Metropolitan Area now provide comprehensive medical care for about 700,000 persons or about 8 per cent of the population living in the service area. The official records of the Health Department of the City of New York reveal that the perinatal death rate among the population in the city which receives prepaid comprehensive medical services from HIP medical groups is substantially less than among other private patients who are under the care of fee-for-service solo practitioners. The same sharp differences in perinatal deaths under the two differing systems of medical practice and prepayment occur among white and non-white populations, and among families of wage earners in comparable occupations and those earning comparable wages.

The loss rate during the gestation period is also consistently lower under prepaid comprehensive group practice (HIP). There are fewer infant deaths during the first seven days after delivery. The average weight of infants at birth is better in the HIP population. According to Health Department records, the perinatal death rate among babies born to HIP families in the three years 1955, 1956, and 1957 was 23.1 per 1,000 deliveries compared with 27.9 for New York City babies delivered in hospitals by private physicians, a difference of almost 20 per cent. The prematurity rate was also lower in HIP.

Two years ago the Department of Welfare of New York City, with the approval of the State Department of Social Welfare, replaced solo practitioners who had been serving 13,000 aged persons living at home by the services of six HIP

medical groups prepaid by the Department on a capitation basis. The Department also contracted with these medical groups for the medical care of 1,600 aged persons living in 22 nursing homes. There followed a striking improvement in quality of medical care. The benefits of organized medical care include daily medical rounds on the aged in nursing homes, continuity of ambulatory medical care and social services, and the finding of many remedial disabilities, such as undiscovered incipient glaucoma among many of the aged, some of whom require continuing treatment to prevent progressive loss of sight. As a result of this and other experiences the Welfare Department has extended its contract with these and other HIP medical groups to the care of 1,500 additional aged persons residing in 13 other nursing homes.

Under a prepaid system of organized medical care, preventive services of various kinds are more freely available to people of all ages—not only children but also adults. The early detection of breast cancer, of uterine cancer by periodic Papanicolaou tests and cervical biopsies, the systematic follow-up of pregnancies and the early identification of the relation of infant abnormalities to natal and prenatal factors in the mother—these are cited as a few examples of preventive services which can be conducted systematically on a population which is insured for continuing comprehensive care by prepaid medical groups. Such an insured population remains comparatively stable over the years and therefore lends itself for long-term research in epidemiology, demography, human ecology, and in the behavioral and social science fields related to public health.

The large size of the HIP population available for continued observation (now almost 700,000 persons) is an obvious advantage. It is about 20 times that involved in the Framingham Study conducted by the Public Health Service. Still another advantage is the rapidity with which accurate information can be accumulated under a system of organized medical care with good clinical records and efficient reporting to a central source. The Public Health Service is now investing about $1,000,000 in an HIP study of coronary artery disease which promises to provide greater knowledge of its course after diagnosis and of its relation to a variety of personal characteristics, habits, and working experience. The federal government is also investing large sums in a long-range X-ray mammography study which is to determine to what extent the survival rate of women with breast cancer is actually affected by this method of facilitating earlier detection of malignancy.

CONTINUITY OF MEDICAL CARE: THE PLACE OF THE FAMILY COUNSELOR

Eighty-eight per cent of all physicians' services (doctor-patient contacts) are rendered outside the hospital—in patients' homes, in doctors' offices, and in medical care centers. These services involve 30 or more different types of specialists and subspecialists in addition to family doctors. As family practitioners decline in number and prestige, patients gravitate directly to specialists, often to the wrong kind. Today in New York City specialists provide up to 60 per cent of all physicians' services. Among the majority of our people of low and moderate income on a fee-for-service system of payment, continuity of family medical care has become a myth.

A follow-up study of medical school graduates made by Dr. Herman Weiskotten for the American Medical Association and the American Association of Medical Colleges some years ago revealed that only 15 to 20 per cent of physicians remain in general family practice 10 years or more after graduating from medical school. In Boston the figure was 5 per cent. The vacuum is being

filled by foreign physicians, many with inferior training.

Under the prevailing system of solo practice there are no enforceable standards of quality, no supervision of professional performance, no determination of errors of omission or commission in practice, no measurement of waste in unneeded services and costs which needlessly exhaust the financial resources of the patient and of insurance carriers.

Perhaps the most serious health problem affecting the nation is the progressive decline in the number, the quality, and the professional status of family physicians. Under the existing order, the better-qualified physician will not long continue to carry the burdens of a family physician with its lower social and professional repute if he can become a specialist with a more remunerative and less burdensome occupation. The downward trend in the number and quality of general practitioners continues, despite the valiant efforts of some medical schools to train family physicians specifically for solo practice and the efforts of Academies of General Practice to improve the lot of their members.

The isolation of the family physician from the hospital-based specialists under the British health scheme is a movement in the wrong direction. So important is the role of the family physician in maintaining the continuity of medical care and as a family counselor that we must evolve a means and a method to make the family physicians worthy of being the quarterback on the medical team. This can be accomplished, I believe, only under an organized system of comprehensive prepaid group practice in which the family physicians on the team have a continuing responsibility for the health and welfare of certain families enrolled under their care. They cannot be bypassed by patients on their way to specialists of the group. On the other hand, they are not influenced by a profit motive to retain patients who

should be referred to a specialist, and therefore they restrict their services automatically within the limitations of their professional competence. Their professional work is also watched by the group's medical director and by the chief internist of the group's medical department. The nature of their referrals to the laboratories and to the specialists of the group, as well as their clinical records, reveal any serious errors in performance. The family doctor's elevated status and his key importance in the medical group soon assures him financial rewards and a professional standing comparable to that of the specialists. In fact, he is the group's specialist in family counseling and guidance, not a general practitioner. Because of their importance as key members of the medical group, many of the family physicians in group practice are board-qualified internists or board-eligible.

I do not know any better solution to the problem of how in this day and age to attract and retain some of our best medical men in this most essential career of family counselor than through the prepaid comprehensive group practice of medicine. In making this broad generalization I must except certain well-trained internists who have been attracted by a lucrative solo practice as family physicians to the financially well-endowed segment of our society. Those of us who may circulate in this favored social milieu are apt to overlook or ignore the growing scarcity of competent family doctors among the low-income segment of our urban populations who comprise the vast majority of our people. This scarcity has been largely responsible in recent years for the increasing and often overwhelming flood of patients to the emergency services of hospitals throughout the country, where hurried episodic care for an overload of casual patients is the order of the day. Hospitals have not as yet found a way to stem the recent flood tide of so-called emergency clinic care, for which the breakdown of family practice

among the masses in our densely populated urban areas is directly responsible.

THE RETARDING INFLUENCES

a) *The Attitude of Organized Medicine*

The opposition of the American Medical Association in 1932 to the recommendations of the CCMC regarding the need for organization of medical services, especially to its recommendation of group practice and to prepayment for comprehensive medical care by medical groups, has slowly shifted during the intervening years to a more realistic position. The Association no longer disapproves of prepaid group practice. Its Larson Committee a few years ago inspected a number of prepaid medical groups and reported that they provided services of good quality. In 1959 the Judicial Council of the AMA ruled that the participation of physicians in prepaid group practice under a nonprofit health insurance plan is not unethical.

Unfortunately, this altered attitude of the AMA has not filtered down to most of its constituent state and county societies. Twenty-six state legislatures have been persuaded by state medical societies to enact laws which prohibit the establishment of prepaid medical group practice or of any nonprofit health insurance plan unless approved by 51 per cent of the physicians in the state, and in some states by 51 per cent of the physicians in each county. Two states, Illinois and Ohio, subsequently repealed the obnoxious law and in another (New Jersey) the highest court of the state has recently declared the law to be unconstitutional and contrary to the public interest.

The AMA has consistently advocated free choice of physician by the American people, yet many local and state medical societies deny the people of their community any opportunity to exercise a choice between prepaid group practice and solo fee-for-service practice. Obstructive tactics by county medical societies or by their members include the denial of hospital staff privileges to any physician who engages in prepaid group practice, no matter how well qualified he may be professionally and socially. In all these years, the AMA has never found a constituent medical society or its members guilty of misconduct because of interference with the people's right to exercise a free choice between the two legally authorized systems of medical care.

b) *The Attitude of Referral Clinics and Medical Schools*

At the time of the Committee's report, it had been anticipated that some of the thousand or more private referral clinics with full-time professional staffs would be influenced by the report and by the developing needs of the times to extend their services extramurally into the community by offering comprehensive medical care to neighborhood families on a prepaid basis. It was hoped that they would in this manner supplement the episodic type of medicine which had long been the clinics' primary concern. With a rare exception this has not happened for the understandable reason that these institutions depend for profitable clinical cases largely upon referrals from individual private practitioners; their continued support would be jeopardized if the clinic became a more efficient competitor to solo practice.

To my knowledge not a voluntary teaching hospital in this country, except the Montefiore Hospital in New York City and the New York Medical College, is at present sponsoring a prepaid comprehensive medical care group as the CCMC had recommended. A medical school in New York which had once spon-

sored a prepaid medical practice group for several years dropped its sponsorship ignominiously when subjected to pressure by some of its solo-practicing alumni during a fund-raising campaign. Another, in a Midwestern city, which had begun to organize a hospital-based medical group for the benefit of its community and for laudable teaching purposes, abandoned the project while still a-borning when the school was subjected to alumni pressure during a fund-raising period.

c) *The Social Orientation of Young Physicians*

Instruction in the social and behavioral sciences is assuming increasing attention in medical school curricula, yet the exposure of students to personal experience with family and community problems is usually limited to the follow-up of one or more families of patients of the outpatient clinic or to those discharged from the hospital on home care. These programs of so-called "comprehensive medicine" are intended to foster the social orientation of the medical student but they are by no means equivalent in educational indoctrination to active participation by hospital residents in a prepaid group-practice unit of a teaching hospital, which has assumed responsibility for the long-range medical care of neighborhood families. Most medical students are reluctant to interrupt their intensive undergraduate studies for a house call, for they look upon such interruptions as a time waster during this critical period of their scientific education. For this reason casual participation in such programs is not popular among undergraduates.

Exposure to the social and behavioral problems which affect the health and welfare of families can best occur, I believe, during the later years of residency training when the young physician is learning how to practice medicine as a member of the society in which

he is to function as a future family counselor. Work in a group-practice facility of the teaching hospital, rather than in a conventional outpatient clinic, enables him to learn by actual experience how to participate in the private practice of medicine in the same coordinated relation to his professional confreres of various skills as he did while a student of medicine on the hospital wards.

A recent broadening of the Federal Medical Facilities Program authorizes grants-in-aid to hospitals for the construction of diagnostic and therapeutic facilities for an ambulatory population. Under this program the Montefiore Hospital has recently been awarded a substantial federal grant for a new building to be erected by the Hospital solely for its medical group, which now provides prepaid comprehensive medical care for about 10,000 insured families. Few teaching hospitals will be tempted to follow this brave example unless governmental safeguards are enacted against renewal of the local town-and-gown conflicts which are likely to follow any change whatever in the existing order of medical practice and teaching. Up to this time, most professors of Preventive Medicine in our medical schools have turned their faces the other way. Kentucky has established a rural preceptorship. Temple University Medical School is planning an educational program of comprehensive family care. In view of the ignominious retreat by two other medical schools when confronted with alumni pressure, it remains to be seen whether this worthy plan will come to enduring fulfillment.

Sooner or later the tide must turn, for it is the prevailing conviction that health insurance, voluntary and governmental, will soon encompass virtually the entire population, including the indigent. Teaching hospitals of medical schools may then be obliged to enter

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