ORGANIZATION AND FINANCING OF MEDICAL CARE IN THE UNITED STATES

Part One. Bibliography

I. GENERAL


A compilation of studies commissioned by the AMA on selected phases of medical economics. Volume I includes summaries of three additional volumes.


The most dramatic finding of the 1958 HIF resurvey of the same issues covered in its 1953 survey is the 42 percent increase in consumer expenditures for personal health services due to both rising use and rising prices. Hospital care and drugs accounted for about two-thirds of the rise. Although hospital care was still the most adequately covered by insurance—nearly 90 percent of gross expenditures—the relation of insurance benefits to expenditures showed no improvement. According to the authors, growing public concern has sharpened the issue as to whether the existing medical care "establishment" will continue to operate with a large degree of freedom or whether the use and price of health services will be subjected to various forms of regulation or control.


Professor Harris describes and analyzes a wide spectrum of medical institutions—hospitals, physicians' services, the drug industry, com-

* Compiled by Anne Ramsay Somers, Research Associate.
** Items from this list should be ordered directly from the publishers. Addresses are given in connection with each reference.
*** Limited to books published since 1956 and still in print.
pulsory and voluntary health insurance, medical schools. He concludes that, in all of these areas, American medicine is much more expensive and less productive than the circumstances warrant. A former supporter of national health insurance, Harris explains why he changed his mind and why he believes passage of health insurance for the aged under social security would further reduce the need for a general government program.


Dr. Klarman, an economist who is thoroughly familiar with the institutional idiosyncrasies of medical care, applies traditional economic demand and supply analysis to such problems as the effect of health insurance on utilization of health services, the economic bases for public intervention in financing health services, the physician shortage, hospital pricing, hospital planning, and use of the medical care price index.


The mammoth Michigan study, initiated by the Governor’s Study Commission on Prepaid Hospital and Medical Care Plans and supported by the Kellogg Foundation, encompasses 13 separate study projects in four broad areas—consumer behavior; the providers of care, with emphasis on hospitals; payment for care, with emphasis on private health insurance; and “controls”—defined as “the mechanisms that link the system together and give it reasonable unity of purpose.” For the general reader, more concerned with conclusions than methodology, the last section is probably the most interesting. Recommendations with respect to cost, quantity, and quality controls are based on sophisticated analysis of existing institutional relationships and clear understanding of the difficult decisions that will be required of physicians, hospitals, hospital and medical associations, insurance carriers, and legislatures.


The report of this 28-member commission, headed by Dr. Michael DeBakey, is the most original contribution to the policy debate over medical care organization in two decades. Its major, and most controversial, recommendation calls for a nationwide network of regional medical care complexes, centered about medical schools and teaching hospitals, but including community hospitals and health centers. It combines the emphasis on coordination of facilities and programs that dates back to the Committee on the Costs of Medical Care2 and the Commission on Hospital Care3 with the new emphasis on research.

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and academic medicine that have accompanied expansion of federal research programs and the growth of the National Institutes of Health. Significantly, these groups represent power centers that are increasingly independent of the AMA.


Using a supply and demand framework with interdisciplinary tools, the authors present a comprehensive review and an analytical synthesis of the vast amount of data that are accumulating on all aspects of medical care. They conclude with policy recommendations in seven "critical areas": 1) increasing the supply of physicians, 2) organization of physicians' services, 3) rationalization of hospitals and other facilities, 4) control of drugs—prices and efficacy, 5) increasing access to medical care, 6) regulating the rise in medical care costs, and 7) forging new patterns of public-private relationships.


Approximately 100 reprints of articles and policy statements published in the American Journal of Public Health, 1949-1962, provide a vivid record of major developments in U.S. medical care from the viewpoint of the two sponsoring bodies.


Most of the 16 papers and comments reflect the economists' growing preoccupation with methodology rather than policy-formulation. Exceptions include Nora Piore's report on New York City's extensive tax-supported medical care programs (accounting for one-third of all health care expenditures by the residents), Herbert Klorman's discussion of the productivity lag in hospitals and its effect on rising prices, and a four-part discussion of the role of public health in economic development.


A depth study of medical education and medical care, intended to help bridge the widening "town/gown" schism. The theme is suggested by one of Dr. Darley's conclusions: "One of the chief objectives of the
organized medical profession is to protect the comforts and security of today's, sometimes even yesterday's, status quo. It fears the university as a social institution because the university is committed to further knowledge and understanding... which carry implications for change... And yet, if society's expectations of health and medical service of the future are to be satisfied, the objectives and resources... of medical education and medical care must be deliberately based upon the anticipation of change."

2. ORGANIZATIONAL ISSUES


A sociologist examines patient attitudes toward medical care and the doctor-patient relationship in a unique situation where three alternative types of care were available. Among the significant conclusions: highly organized medical practice, such as the Montefiore Medical Group, is acknowledged to be technically superior but is often personally unsatisfactory to the patient. Since this dissatisfaction limits the practical application of scientific medicine, some way must be found to "humanize" this form of practice. One possibility: the development of "subsidiary" professions to help bridge the growing chasm between the medical specialist and the patient.


In the words of one physician, the expansion of hospital-based ambulatory services "will be, over the next decade, the single most striking development in the organization of medical services." The problems, however, were recognized to be legion. "Cattle concepts of care... still predominate; personalized, palatable, compassionate clinic care is still rare." "The cost... which is increasing as rapidly as the number of ambulatory patients and remains essentially uncovered by most insurance plans, is a problem that will become more severe. The application of administrative concepts developed and proven by industry, which might lower costs and heighten amenities, go essentially unexplored." More space could have been devoted to possible solutions.


This companion to the Freidson volume (see above) reports on a foundation-supported, 8-year experiment with a Health Maintenance Team, composed of physician, public health nurse, and social worker, supplemented by specializing consultants organized into a formal group practice. Both Silver and Freidson believe that this pattern, with certain modifications, may be the ideal for the future, combining the scientific and technological advantages of group practice with the more personalized attention many patients still require.

Among the unusual characteristics of this unique hospital-community medical center in Hunterdon County, N.J. are: 1) the emphasis on ambulatory care and preventive services, including psychiatry; 2) the integration of full-time specialists and attending general practitioners into one medical staff; 3) the organization of the specialists on the basis of group practice and a professional service plan with pooled fees and salaried income; and 4) affiliation with a first-rate medical school for supervision and education of the staff. The continued growth and success of the Hunterdon experiment make the story of far more than historical interest.


This nationwide survey, comparable to one conducted by the P.H.S. in 1946, found a three-fold increase in the number of groups and of doctors in these groups. Still, less than 10 percent of the nation’s practicing physicians were in group practice in 1959. Other findings relate to location, size, and organization of groups, methods of income distribution, relation to hospitals, methods of controlling the quality of care, etc.

3. FINANCING: PRIVATE HEALTH INSURANCE


GHI’s director of research reports, on the basis of a two-year research project co-sponsored with the American Psychiatric Association and the National Association for Mental Health, that short-term ambulatory psychiatric treatment is insurable if spread over an average cross-section of population at the present level of awareness of need.


Commissioned in 1958 by the New York State Commissioner of Health and the Superintendent of Insurance, these reports seek answers to the explosive issue of rising health insurance premiums—a nationwide problem. The most important recommendation calls for a statewide hospital planning body, with regional branches and adequate
authority to coordinate and rationalize hospital operations. This has been accomplished, in part, through the hospital review and planning machinery since established by legislation. Major interest in the Blue Shield study centered on the finding of large amounts of poor quality medical care. Continuing medical audits in all hospitals and minimum standards of professional care for all institutions with government contracts were recommended.


This study compares utilization and total costs under three representative types of insurance. In each case, the plan chosen was considered among the best in its class: the New Jersey Blue Cross/Blue Shield combination, the General Electric comprehensive major medical plan, and the Kaiser Foundation Health Plan of Northern California. Contrary to common assumptions, no significant difference was found in hospital utilization under the three, but physician visits were considerably higher at Kaiser. The average outlay for insurance plus out-of-pocket expenses was less under Kaiser than under either of the other plans.


In this scholarly analysis of the acrimonious debate between proponents of “community rating” and “experience rating,” Professor MacIntyre concludes: 1) the distinctions are less substantial than competing carriers have alleged; 2) the advantages of community rating have been exaggerated; 3) total community enrollment on a voluntary basis is impossible under either method; and 4) coexistence of the two, probably with selective reliance on government for high-cost, low-income groups, is desirable.

4. **FINANCING: HOSPITAL CARE FOR THE AGED UNDER SOCIAL SECURITY**


All the testimony pro and con, on the 1963 version of the King-Anderson Bill. Hearings by the same committee in the 87th Congress, on an earlier version, also remain valuable.


The Committee’s historic report recommending a multilayered pro-
gram, subsequently passed by the House, including hospital benefits under social security, supplementary voluntary insurance for physicians' services, etc., and expanded public assistance medical care.

5. MEDICAL CARE BENEFITS AS A FACTOR IN INDUSTRIAL RELATIONS


The impact of collectively bargained health plans on the organization and financing of medical care in the San Francisco Bay Area is examined. Among the conclusions: by creating an organized consumer interest, collective bargaining has had a substantial impact on the institutional relationship among the providers of medical care, the consumers, and the insuring agencies. This includes the pricing structure and the pricing process of the medical profession.


A factual analysis of administrative procedures and problems under the nine most common types of collectively-bargained health plans: 1) indemnity benefits, employer administration, insured; 2) indemnity benefits, employer administration, self-insured; 3) indemnity benefits, trust fund administration, insured; 4) indemnity benefits, trust fund, self-insured; 5) service benefits, employer administration, insured; 6) service benefits, trust fund, insured; 7) service benefits, trust fund, self-insured; 8) dual-choice, employer administration, insured; 9) dual-choice, trust fund, insured.

Part Two. Principal Sources of Basic Data


Number, size, control, facilities, accreditation, personnel, finances, and other hospital data; also an individual hospital directory.


Enrollment, premiums, benefits, and related data as reported by the commercial insurance industry.

Medical Economics, Oradell, N. J.

Annual survey of physician incomes by specialty, type of practice, etc.


Periodic reports on hospital, medical, surgical, and other benefits provided in major collective bargaining agreements are included in this series.

Annual averages and quarterly indexes for selected items and groups. Beginning with 1965, this report will temporarily be published for the months of June and December only.


Number of physicians, dentists, and nurses; medical care expenditures; health insurance; hospitals; medical care prices, etc.


Periodic reports on the financing and utilization of medical care.


Periodic reports on the number and characteristics of physicians, dentists, nurses, and other health occupations; also a listing, with characteristics, of the major professional schools.


Periodic reports on morbidity, use of health services, health insurance, enrollment, etc., as well as on methodological problems, from the principal center of United States health statistics.


Amount and percentage distribution, by type of care (hospitals, physicians, etc.) and by type of payment (direct patient payment, insurance, etc.) going back to 1948.


Total public and private expenditures for health and medical care, also as percent of GNP, with annual comparisons going back to 1929.