large communities is involved. These problems do not concern us here as we have limited our discussion to the towns and villages in which most urban Candians live.

However enough has been shown to make clear some of the forms which emerge in the town when its functions are encouraged to grow and integrate logically. Arranging for such tendencies to replace an obsolete town plan over a period of years through the agency of a loosely knit master plan is no easy job. It demands a city or town planning commission composed of a small number of competent persons who can keep the broad picture of the town's development in front of them, who have co-ordinating control over the other municipal departments and who have a competent research and planning staff backed by an enlightened and lively public interest expressed at public hearings and through the press. And it needs financial measures and land use control legislation to enable the commission to plan positively and not merely negatively. It is only through the formation of such empowered commissions now and their thorough survey and preparation of the ground before the reconstruction period comes upon us, that the physical structure of our urban and small town environment can be changed permanently for the better.

Dispute over the U. S. Health Insurance Act

By Alton A. Linford

WHAT Dr. Morris Fishbein, editor of *The Journal of the American Medical Association* calls the "Thirty Years War" of American Medicine against public health insurance reached a new high in intensity during the past year, provoked anew by the filing in the United States Congress of the Wagner-Murray-Dingell Bill. Organized medicine, through its national, state and local journals and, more importantly, through its propaganda front: "The National Physicians Committee for the Extension of Medical Service," organized and conducted the most ambitious and extensive counter-campaign in its long history. Individual doctors, newspapers, magazines, columnists and ordinary citizens have been the object of a barrage of pamphlets, leaflets, syndicated editorials, articles, and radio addresses aimed at the defeat of this bill. Large commercial drug companies, doctors and other individuals have responded generously to a nationwide appeal for funds to keep the printing presses and the radio working overtime to turn out this material.

The uniform and persistent theme of the campaign has been that this bill represents an attempt on the part of a clique of "bureaucrats" in Washington to centralize more government in Washington at the expense of the States; to "destroy the private practice of medicine" and to substitute for it an article variously referred to as "socialized medicine," "bureaucratic medicine," and "political medicine," to set-up a one-man "dictatorship" over United States medicine under which people would have to go to a doctor assigned by a Washington bureaucrat, and under which doctors would be regimented to the extent of being placed on salary and being told where to practice and whom to treat.

This campaign has had the support generally of private business, especially the large pharmaceutical manufactures, the retail drug stores, the press and such organizations as the American Bar Association and the Catholic Welfare Council.

The sponsors of the bill are the two large labor organizations: American Federation of Labor and the Congress of Industrial Organization. Other groups supporting the measure are the Lawyers' Guild, the Physicians' Forum, and the

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Committee of Physicians for the Improvement of Medical Care—the latter two, liberal and progressive organizations of physicians.

The proponents of the Bill have displayed a desire to have the measure widely and constructively discussed, and a willingness to accept amendments. When introducing the Bill, Senator Robert F. Wagner of New York said: "I do not claim this bill is in any sense a perfect instrument; it is offered simply as a basis for legislative study and consideration." It must be recorded that this invitation for frank and honest criticism with a view to agreement regarding a better program, has had a minimum of response on that level. Most of its opponents have admitted nothing good about the measure and have chosen rather to attack it in toto as a wholly bad and undesirable proposal.

Because the campaign has produced much heat and almost no light, this article was prepared for the purpose of presenting the provisions of the Wagner-Murray-Dingell Bill and something of its origin and background.

Extends and Enlarges Social Security Program

The first fact that should be made clear is that the bill provides for more than medical care—though it is true that the medical provisions have drawn the most fire. In a word, the bill amends the Social Security Act by expanding, extending and enlarging the present social security program.

This program includes unemployment compensation, old age and survivors' insurance and three categories of public assistance: old age assistance, aid to dependant children and aid to the blind. The new Bill would add cash benefits for temporary and permanent disability, maternity benefits, special unemployment benefits for unemployed service men and grants-in-aid for general public assistance (poor relief) Other objectives of the bill are inclusive of new groups entitled to benefits and liberalisation of existing benefit schedules. But the most important feature of the Bill is of course its provision for complete medical services including general physicians and specialists' care, hospitalization and laboratory service.

The bill proposes to galvanize all of these services into a single unified system of social insurance, financed by a single tax (six% each from workers and employers), to be administered directly by the federal government.

Origin of the Bill

Though its opponents insinuate that the Wagner-Murray-Dingell Bill is but the latest and wildest figment of the imaginations of a small group of bureaucrats in Washington, it may fairly be said that the bill embodies the major recommendations of all of the leading research and planning agencies in this field—both private and governmental: The National Resources Planning Board, the Social Security Board, the Interdepartmental Committee to Coordinate Health and Welfare Activities (1938), the earlier Committee on Economic Security (on whose findings and recommendations the Social Security Act was based, 1935), and the Committee on the Costs of Medical Care (private, Final Report, 1932).

This bill proposes to put into effect the so-called "United States Beveridge Plan." The enactment of this measure would appear to be a reasonable step forward in the building of a comprehensive system of social security, a part of which was enacted in 1935 as "The Social Security Act." The adoption of this or a similar measure is a minimum essential, if the people of the United States are to be "assured freedom from want."

The citizens of the United States now enjoy a modicum of security against the hazards of unemployment, old age, industrial accident, and the premature death of the family breadwinner, but they have no protection against wage loss due to illness, and they have no means (except through scattered and limited voluntary prepayment plans) to

assure themselves getting and being able to pay for medical care during illness. The Wagner-Murray-Dingell Bill would provide fairly complete medical and health security, and would greatly increase the measures of security against the allied hazards of unemployment, old age, and dependency due to the death of the wage-earner.

At this point we should examine more closely the medical provisions of this much controverted measure.

Medical Services Provided

A fairly complete medical service is provided including "general medical, special medical, laboratory, and hospitalization benefits." Panels of practitioners and hospitals are to be established from which the patient will select his doctor, and from which the physician and patient will select a hospital when it is needed.

The hospitalization benefit is limited to 30 days in each benefit-year, except that it can be increased to 90 days "when the Board of Trustees finds that money in the separate (medical) account are adequate." The laboratory benefit is defined broadly to include "chemical, bacteriological, pathological, diagnostic and therapeutic X-ray, and related laboratory services, physiotherapy, special appliances prescribed by a physician, and eye glasses prescribed by a physician or other legally qualified practitioner."

"General medical benefit" is defined to cover "all necessary services such as can be furnished by a physician engaged in the general practice of medicine, at the office, home, hospital, or elsewhere, including preventive, diagnostic and therapeutic treatment and care, and periodic physical examination." The services of the specialist is to be available when, in the judgment of the general physician, t hey are required.

Dental and Nursing Services

It will be observed that the bill does not provide for dental and nursing service. The Surgeon-General and the Social Security Board are, however, charged with jointly studying the matter with a view to recommending legislation within two years which will provide for dental, nursing and other needed benefits not already provided in the bill.

Limitations and Safeguards

As a safeguard against possible abuse, the bill authorizes the Surgeon-General and the Social Security Board, by joint regulation, to require patients to pay the general physician for the first visit, or for each visit in the course of an illness. The fee, however, must be a nominal one so that it will not become an obstacle to needed medical care. Another safeguard is provided in that these same authorities are authorized to fix the amount or duration of the laboratory benefit.

Such safeguards are probably essential in view of the imponderables present when inaugurating a plan as ambitious as this one. Despite these limitations, the scheme would undoubtedly make available a medical service which to millions of United States citizens is simply beyond their present means to command, both because of lack of facilities and more importantly, the sheer inability to pay for it.

Coverage

These medical services are to be made available to substantially the whole of the working population and their dependents including the self employed, all of those employed for wages or salaries, including employees of educational and non-profit organizations (except ministers and members of religious orders), farm workers, and domestic help. Provisions are made whereby states and local governments may enter into contracts with the Social Security Board for the inclusion of their employees and their dependents, and also for "welfare" or "public assistance" cases that are dependent upon state and local government. The number of persons who would be covered by this system is estimated to approximate 110,000,000 or about 85 per cent of the total population. This group, it should

be emphasized again, includes not only most of the gainfully employed in the country, but their dependents as well.

Administration

One of the most sharply criticized features of this bill is the one under which, it is alleged, the Surgeon-General of the United States Public Health Service becomes a virtual dictator over United States medicine. Actually the bill divides authority between the Surgeon-General and the Social Security Board, and the regulations of each must have the approval of the Federal Security Administrator—in whose over-all organization (Security Agency) both the Social Security Board and the United States Public Health Service are located. Generally speaking administrative responsibility over the technical and professional aspects of the program are given to the Surgeon-General, who is always a physician, and the custody and expenditure of funds is delegated to the Social Security Board.

The Surgeon-General is appointed by the President for a four-year term. He is always a physician and is traditionally reappointed to succeed himself, so that there has been singularly little "politics" connected with the office. The position has been held by a line of able and distinguished physicians.

Though of necessity the Surgeon-General is given very wide powers, he is bound by a series of twelve "guiding principles and provisions for administration," and he is required to consult with an advisory council of sixteen members on all important matters. Among the Surgeon-Generals most important duties, under this bill, are to publish and make available locally lists of physicians who are willing to give general medical service; to determine what physicians may serve as specialists; to designate standard hospitals; and to establish hearing and appeal bodies to deal with complaints from any interested party, including physician, beneficiary, hospital or laboratory. Finally, he is "authorized and directed to take all necessary and practical steps to arrange for the availability" of all of the medical services provided by the bill. In order to accomplish this objective, the Surgeon-General is empowered to "negotiate and periodically to renegotiate agreements or cooperative working arrangements with appropriate agencies of the United States, or of any state or political sub-divisions thereof, and with other appropriate public agencies, and with private agencies or institutions, and with private persons or groups of persons, to utilize their services and facilities, and to pay fair, reasonable, and equitable compensation for such services and facilities."

The National Advisory Medical and Hospital Council

The Surgeon-General is to be advised by a National Advisory Medical and Hospital Council of sixteen persons, appointed by the Surgeon-General for four year overlapping terms. Members of the Council are to be selected from "panels of names submitted by the professional and other agencies and organizations concerned with medical services and education and with the operation of hospitals and from among other persons, agencies or organizations informed on the need for or provision of medical, hospital, or related services and benefits."

This Council advises the Surgeon-General on such matters as: (1) professional standards of quality to apply to general and special medical benefits; (2) the qualifications of specialists; (3) methods of establishing and maintaining high professional standards; (4) the setting and maintaining of hospital standards; (5) methods of paying for medical and hospital services; (6) research regarding the standards of medical practice as delivered; (7) making grants-in-aid for medical education and medical research; and (8) the establishment of special advisory, technical, local or regional boards or committees.

The bill has been criticized because it does not require the Surgeon-General to follow the advice given him by this

advisory council. One important group, the Committee of Physicians for the Improvement of Medical Care, urged that the bill be amended to require the Council's advice on all matters of policy and also to publish this advice, so that the public would know whenever such advice was not being followed. It should be said that centralization of administrative responsibility in one well-chosen executive, such as this bill provides in the Surgeon-General, is supported by most students of government and public administration.

Guiding Principles

The bill contains a statement of twelve guiding principles by which the Surgeon-General is bound in putting the system into operation. These principles require that "any physician legally qualified (licensed) by a state" be permitted to participate by having his name placed on the panel of general physicians. Full and free choice of physician by the patient and of patient by the doctor is assured. Individuals are to select their general physician from the panel lists published for that locality, subject to the physician's willingness, and subject to a numerical maximum which the surgeon may fix for one physician. Under this bill a legally licensed physician may not pose and practice as a specialist unless he is one in fact and so certified by the Surgeon-General "in accordance with general standards previously prescribed by him after consultation with the Council and utilizing standards and certifications developed by competent professional agencies." General physicians and specialists in each area are themselves to decide upon the method by which they prefer to receive payment for their services. This method may be (1) fee for service according to a fee schedule approved by the Surgeon-General, (2) per capita, (3) salary, whole or part time, (4) any combination of these methods. The services of specialists are to be available upon the advice of the general physician. The bill requires the Surgeon-General in his administration to provide for prompt and efficient medical care; to promote personal relationships between physician and patient; to promote professional and financial incentives for the professional advancement of practitioners and to encourage high standards of service.

Hospitalization

After consulting with the Advisory Council, the Surgeon-General must set up standards for hospitals giving service under the bill. He must see to it that approved hospitals have the necessary medical and other personnel, laboratory equipment and other facilities necessary in order to render service of a high quality. Hospitalization benefits are limited to 30 days in each benefit year and may be increased to 90 days if it is found that the funds are ample. Payments for hospitalization may be made directly to the hospital for service rendered or to the beneficiary in the form of a cash benefit from which he himself can pay his own hospital bills. The daily per capita payment for hospitalization may vary from $3 to $6 according to the quality and amount of care and the geographic area where the hospital is located.

Medical Education, Research and Prevention of Disease and Disability

The bill provides for federal grants-in-aid to "non-profit institutions and agencies engaged in research or in undergraduate or postgraduate professional education." The Surgeon-General after consulting with the Council would distribute these funds among projects on the basis of their "promise of making valuable contributions to the education or training of persons useful to or needed in the furnishing of medical, hospital, disability, rehabilitation, and related benefits . . . or to human knowledge with respect to the cause, prevention, mitigation, or methods of diagnosis and treatment of disease and disability."

Finances

It is estimated that $3.5 billions was spent in 1942 in the United States for

medical care. About 75 per cent of this amount was paid directly by private individuals in return for service, some 20 per cent was raised by taxation and about 5 per cent by philanthropy and industry.

The Wagner-Murray-Dingell Bill proposes to raise this money by means of a pay-roll tax on both workers and employers. The bill provides for a single tax of 6 per cent on wages and salaries (no tax on that part of one persons wages or salary which exceeds $3,000) to be paid by both employers and workers—the proceeds to finance a series of benefits—old age, survivors, unemployment, maternity, medical and hospitalization. Self-employed individuals would pay 7 per cent of the total, one-quarter would be set aside into a "Medical Care and Hospitalization Account" out of which all medical and hospitatlization benefits would be paid.

The critics of the bill, by the use of innuendo, have tried to create a popular impression that the $3 billions to be placed in the "Medical Care and Hospitalization Account" was an amount greatly in excess of present expenditures for medical care and also that it would be in addition to present expenditures for medical care. The facts are, of course, that expenditures from this fund would largely replace present medical expenditures and, being more wisely spent, would prebably purchase more medical care at no increase in cost.

It is important to note that the 12 per cent total payroll tax proposed by this bill would not all be new taxes. The present social security taxes amount to 5 per cent—4 per cent paid by the employer and 1 per cent paid by workers. Increasing the tax to 6 per cent on each would raise the employers tax a mere 2 per cent, while employees would find their taxes raised from 1 to 5 per cent—a 500 per cent increase. This proposed distribution of the increased 7 per cent tax is noteworthy in view of the fact that the bill is sponsored by organized labor. It is evident that labor is asking only for that for which it is willing to pay its proper share.

Conclusions

It will be observed that the Wagner-Murray-Dingell Bill is so drawn that there would be a minimum disturbance of the traditional private practice of medicine with free choice of physician. Under this measure, physicians would continue to be licensed by the states as at present. Doctors would continue to "hang out their shingles" in communities of their own choosing and practice in offices which they themselves have selected and equipped with such apparatus as their financial resources would permit.

Hospitals would remain under their present sponsorship and administration, regardless of whether they be public or private.

The chief point of change would be that both doctors and hospitals would no longer look to the patient for the payment of the bills, but rather to the trust fund into which the worker had already paid his money.

This system would free the patient of the worry and strain of fear lest a costly illness overtake him while his family is young and his other financial responsibilities are great. With his bills paid, the patient would seek medical care early and would be able to cooperate more fully with the doctor in the business of getting well,

If the doctors choose to be paid on the basis of fee for service, it is difficult to see how the methods of providing medical service will be changed perceptibly by the introduction of this measure. It is anticipated that better use will be made of existing medical facilities—because with the bills paid in advance, people who now go without or delay too long, will seek medical care when it is needed. Medical facilities should better distribute themselves throughout the country because doctors, hospitals and other medical facilities can afford to locate in communitites that now cry out for them, but have to do without because the family incomes of the resident families will not support these medical services.

It is true that hospitals must, under this bill, meet certain minimum standards as determined by the Surgeon-General

and his Advisory Council. The better hospitals will certainly experience no difficulty meeting these standards. Substandard hospitals will have a stronger motive for improving their service and facilities.

One of the strongest and most persistent arguments against the Wagner-Murray-Dingell Bill, and all other measures involving compulsory health insurance, is that such compulsory measures, involving governmental participation, are unnecessary because private voluntary plans can do the job. The marked growth of Blue Cross Hospitalization Plans in recent years and the steadily increasing number of voluntary group-prepayment medical care plans are cited as evidence that voluntary insurance can be expanded to cover the whole of the working population.

What are the facts? It is true that voluntary medical and hospital plans have shown remarkable growth, particularly the latter. Blue Cross plans are available in parts or all of 40 states, and membership covering 14 million persons is claimed. Medical care plans of varying types are available in a dozen or more states, with a membership estimated variously from 1.5 to 7 million persons.

Against the optimistic claims of the proponents of voluntary health insurance are these sobering facts. The rate of growth of the Blue Cross membership in 1943—the year of the nations greatest national income—appears to have leveled off. If the public is manifesting a slowdown in its willingness to purchase voluntary hospital insurance at a time when family income is at an unprecedented peak, it is difficult to be optimistic about what the trend will be when family income drops to more normal levels and when the supply of available consumers goods becomes equal to the demand again. It should further be noted that the 14 million members of Blue Cross represent only 10 per cent of the population of the country. One can be even less optimistic about the voluntary plans offering physicians's services. No more than one or two have memberships exceeding a few thousand, and most of them offer an extremely limited service—such as surgery and obstetrics, instead of the comprehensive medical service offered by the Wagner-Murray-Dingell Bill. Almost all of these plans set an income leve at from $2,000 to $3,000, which excludes just the people most likely to buy voluntary insurance.

Finally, the proponents of voluntary health insurance fail to recognize a very basic fact: in ordinary times the national income is so distributed among families in this country that from 40 to 60 per cent of them need more than their full incomes to purchase such essentials as food, shelter, clothes, and fuel. In other words approximately one-half the population—and this is a conservative estimate—cannot be reached by voluntary health insurance, because they just don't have the money to purchase it. The ineffectiveness of most voluntary plans is assured by their insistence upon an income limitation which makes it available only to those who cannot afford to buy it.

The people of the United States, like the people of other lands, desire economic security almost above all else save peace. They are becoming increasingly aware of the large role which illness and the high cost of medical care play in present family insecurity. They realize that adequate medical care is as essential to family well being as food and shelter and clothing. They know that the resources of the country can be organized in a way to assure all of these essentials to every person. The Wagner-Murray-Dingell Bill would accomplish this in large part, and it probably is only a question of time until the people will demand it.

Just now, it appears that the medical and hospital titles of the bill are beaten temporarily so far as enactment this year is concerned. To this extent organized medicine's campaign has been successful. It seems likely, however, that the "victory" will be short-lived, and that future historians will characterize it as a "rear-guard action" which only delayed the realization of the peoples' demand for a public program providing full medical and health security for all.