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Health and the Search for Equitable Access: An International View

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HEALTH AND THE SEARCH FOR EQUITABLE ACCESS:

AN INTERNATIONAL VIEW

SUBMITTED IN PARTIAL FULFILLMENT

Of the requirements for the degree of Master of Science.

LINDENWOOD COLLEGES

TO

JOHN McCLUSKY, Ph.D.

FACULTY ADMINISTRATOR

and

LAWRENCE M. MILLNER, Ph.D.

FACULTY SPONSOR

WILLIAM A. NORWOOD

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Chapter 1

Introduction: American Medical Care Today

For many years the American people have sought to make their health care delivery system more responsive to their needs, and it is likely that these efforts may accelerate in the years ahead. Thus, the Carter Administration has made a commitment to introduce some form of a national health insurance. Also, the results of a recent Roper survey indicated that the public believes that despite the nation's rapidly expanding outlays for health care, it should further increase them.

Since government--federal, state and local--is now the source of more than two of every five dollars expended for health care, the control and reform of the health care industry is, and will certain remain, in the political arena. An advanced technological society such as the United States can no longer rely exclusively on the private sector to provide the goods and services, including health care, that it needs, wants and can afford (Social Security 40).

The limits to what government can accomplish go beyond the number of dollars that it is able to appropriate. Ours is a representative democracy; those elected must remain sensitive to the values, goals, interests and fears of critical groups that helped to elect them and that can, if sufficiently disturbed, defeat them at the next election. The scope for governmental initiative on any issue is always limited by the changing forces in the political arena.

The American people have clearly come to expect much from medicine, especially in recent years, but they have matched these rapidly rising expectations with rising anxieties over the cost, quality and accessibility of health services.

Some of the proponents of a national health service argue that since almost every other modern, industrialized country has included health care within its system of social insurance, the United States should do likewise. These proponents feel that since our social legislation currently offers protection against other contingencies--for example, loss of income, permanent disability, old age, and death--it should expand its scope to include health insurance. And they have allies among those who doubt that low income groups will ever have adequate access to health services unless our society "socializes" the costs of such care. Still others are convinced that the current "non-system," as they refer to the production and distribution of health care services, cannot be rationalized until a national system of financing medical care is established.

Some of the antagonists believe that the shortcomings of our present health care system can be remedied without the disturbances that would accompany major reforms, by providing coverage for those not now covered or covered inadequately by private insurance or by governmental programs.

This paper is an attempt to clarify and propose remedies for problems relating to the health care system of this country, by

examining the existing health care system of four other countries. I have chosen Sweden, Great Britain, the Soviet Union and the People's Republic of China.

I plan to focus on four specific areas of concern: hospitals, site of practice of doctors, payment mechanism of doctors and equitable accessibility of health care. I believe these topics to be the most relevant and best suited to give the reader an insight into the overall health and medical care systems of the countries covered.

Other topics, such as social status of doctors, out-of-pocket expenses by the patient, training of physicians and infant and maternal mortality rates will not be addressed for two reasons: first of all, there was a need to limit the length of this paper; and secondly, there was a lack of sufficient information about these topics on at least one of the four countries.

Since equity is such an elusive term, I would like to qualify it by defining it as the establishment of an acceptable level of care for all persons, irrespective of their poverty or wealth. This, of course, does not imply that the same level of care should be made available for everybody. An acceptable level of care for all is realistic and can be achieved; a single standard of care for all would be utopian. There are substantial differences in every other service sector--in education, in recreation, in housing. There is no reason to believe that these differences could be eradicated in health.

However, acceptable care for all should include appropriate diagnosis, advice, reassurance, and, if necessary, treatment, together with

rehabilitation and an emphasis on educating people in preventive care. This is an essential goal of a society's health and medical care systems. This care should simultaneously include appropriate technical knowledge and skill; warm, humane personnel; and finally the use of techniques culturally acceptable to the specific population.

The societies of the countries I have chosen range from the highly urbanized to the predominantly rural; from a country with a population only slightly larger than New York City, to the country with the world's largest population; from those with a system of government which places high regard for personal freedom to those where the individual citizen has essentially no personal latitude, but must be responsive to group and state. What these four countries have in common, however, is that each has made a significant effort to develop its health care system in a highly planned and organized way.

I will explore, for example, how the British system is based on that dying breed in American medicine--the general practitioner; how Sweden combines public planning and private enterprise; how the Soviet Union delivers the world's most highly planned and centralized cradle-to-grave coverage; and how China promotes mutual-aid programs and uses the health care system as an instrument for social change.

In looking at these four other systems, I will also briefly examine each individual system's historical roots and attempt to trace its evolution.

It is my hope that we can better analyze the current dilemmas in the United States through an examination of how other societies have

handled theirs. The fact that I will be studying societal structures so different from our own does not prevent the possibility of learning by comparison, because what we are talking about is not obviously a simple transplantation of systems, but the insights provided by markedly different approaches to the solution of comparable problems.

The inevitability of changes in the health care system stems from the fact that, in a dynamic society such as the United States, with a population that is both increasing and relocating, with gains in real income, changes in lifestyles, and advances in science and technology, the health care system of 1985 must differ from that of 1965.

I plan to conclude this paper with relevant suggestions intended to help facilitate this change, keeping in mind the four areas of concern I have stated above.

Chapter 2

Sweden: The Case for a Universal, Compulsory, State-supported Insurance System

Sweden is of particular interest to us because the health of the people, by almost any statistical measure, is equal to or better than the health of the people of any other country in the world.

The establishment of a comprehensive health care system in Sweden was facilitated by three historical factors. First, most hospitals were traditionally owned and operated by the government. Second, the physicians who cared for the sick in the hospitals were largely salaried and essentially limited in their practice to the hospital. And third, "Provident Societies" (a way of dealing with the costs of medical care and with the loss of income during illness) have existed in Sweden since the time of the medieval guilds. They were voluntary associations set up to help the indigent.

As early as 1663, a royal charter established the Collegium Medicum, the forerunner of the present National Board of Health and Welfare, and during the next century its sphere of responsibility was greatly extended. It was given the additional duty of providing for smallpox innoculation, for the supervision of the general care of the sick, and for the investigation and prevention of venereal disease.

In 1931, the government began to provide grants in aid to the voluntary sickness benefit societies, and a local voluntary health

insurance program was established. By 1954, almost 10 percent of the population was covered by sickness funds, and in 1955, all health insurance funds were merged and a compulsory insurance system was founded under government control.

According to Sweden's medical care system, every working person must pay into a social security fund, as does his employer. In return, all the hospital bills are paid in full, as well as three quarters of all doctor's bills and half of all prescription drugs, except life-saving drugs like insulin, which are paid in full. But the Swedish health package goes much further than this: for instance, when a person is sick in Sweden, he is entitled to financial help after the fourth day of sickness, with the money coming directly out of the social security fund. This financial help can be received up to two years, after which a pension fund takes over.

> Maternal and child health care is provided totally free of charge. Every newborn baby is visited at its home by the district nurse within a few days of birth: the provisions for care of the baby are discussed with the parents and any problems are dealt with. Care for children, including periodic checkups, immunizations, functional tests and counseling, is totally free and provided by pediatric nurses and pediatricians, working in district child-care centers. This is believed to be one of the primary factors in Sweden's extremely low infant and maternal mortality rates. Further medical services to children are provided upon entering school and periodically through the school year (Sidel, 1977, p. 122).

A central point of Sweden's experience with medical care is that perhaps more than any other non-socialist country, it has over the past fifteen years attempted to regionalize its medical care services.

Based on its historic governmental involvement in medical services and on governmental decentralization to the county level, Sweden has sought to develop a system which would include a graded hierarchy of services and an integrated structure for decision-making and fiscal management. Let us turn to an examination of Sweden's system in terms of our four major areas of concern.

Hospitals

Seven health regions have been established, each encompassing between 650,000 and 1.6 million people. Each region includes up to six counties and, in turn, each county contains several health districts whose population ranges between 7,000 to 40,000 people. Within regions, health services are provided at each of the three levels: the region, the county, the district.

The first level of care is provided in district health centers which have from one to fifteen doctors, as well as other medical personnel. It has been estimated that district health centers provide approximately 75 to 80 percent of all outpatient care including individual preventive health care. Most of the physicians in district health centers are generalists, although the larger centers include specialists in, for example, pediatrics, obstetrics-gynecology, internal medicine and psychiatry.

For the second level of care, most counties contain two or three district or "normal" hospitals which serve several health districts encompassing 75,000 to 100,000 people. These are general hospitals,

with fewer than 600 beds, which provide care for emergencies, such as accidents, heart attacks and strokes, and also provide general hospital care.

A third level of care is available at the regional level. Seven regional hospitals have now been established, one in each of the seven health regions; six of these centers serve simultaneously as medical college teaching hospitals. "Superspeciality" services, such as neurosurgery, plastic surgery and radiation therapy, are available at this level.

A fourth, even more specialized level of care is available in a few regional hospitals where relatively rare special services--such as open heart surgery and transplantation work--are performed (Navarro, 1974).

It is evident that Sweden has tried to promote an extensive effort to avoid duplication of expensive services and to rationalize the most costly and prestigious sector of medical care hospitals through the provision of services at the least costly level at which they can be effectively provided.

Site of Practice of Doctors

Some 70 to 75 percent of Sweden's physicians work in hospitals, which will insure a continued emphasis on hospital-based care in the future. They are salaried, and much debate over the past few years has been centered over the amount of salary they should receive.

General practitioners do not have hospital appointments, but provide care outside the hospitals exclusively and make referrals to specialists on the hospital staff.

Approximately 1,000 district medical officers, usually general practitioners, work on salary outside of the hospitals under the administration of the county council. Their responsibilities are in many ways similar to those of British general practitioners--to provide primary medical care and preventive care to patients--but the population covered is a geographically defined district rather than a specific number of people. District physicians often work in solo practice, particularly in the sparsely populated northern areas, although the current trend is toward establishing larger districts where possible, with two or more physicians working in a center. A nurse or a nurse's aide usually works with the doctor, but district nurses also work independently, and problems of isolation--from each other and from other parts of the medical-care system--exist for both the district medical officers and for district nurses.

Even in the provision of ambulatory care, Sweden's health care system is heavily hospital-oriented. Approximately 50 percent of doctor visits are to hospital outpatient departments where many of the physicians are specialists. Of the remainder, about half are to district physicians and half to private practitioners.

Serious problems exist in the continuity of care between the ambulatory care system and the hospital sector. As in England, primary care physicians may not care for hospitalized patients except

under special circumstances; physicians on the staff of the hospitals take over the care once the patient is admitted. Despite efforts to provide the hospital physician with information about the patient and his problems, and to provide the primary care physician with information about the hospitalization and its aftermath, confusion and discontinuity frequently exist (Heath, 1975).

Freedom of location and site of practice for doctors is indeed a fact in Sweden today for general practitioners; freedom of deciding on a chosen speciality is not.

> There are attempts to insure that a significant number of new physicians will work in primary care and one method of insuring this lies in the power of the National Board of Health and Welfare to determine the number of training positions for each specialty as well as for general practice (Sidel, 1977, p. 120).

Furthermore, Swedish health planning for specialties goes one step further. The leverage the central government exercises on the hospitals is in its allocation of medical staff throughout the country. The National Medical Board determines staffing ratios and quality criteria. Hence, while a county can actually build or expand a hospital, it had better not do so unless it is assured of medical staff by the National Board.

Payment Mechanism of Doctors

Almost two-thirds of physicians in Sweden are called specialists and work in hospitals. The remaining one-third are autonomous entrepreneurs.

Physicians in private practice are paid from the sickness insurance funds established by the health insurance act. The central government collects payroll deductions from employer and employees, contributes a portion itself, and distributes this money to the sickness insurance funds, in accordance with the number of physicians, would-be patient population, and past experience. These funds are responsible for their own solvency.

The physicians have no contractual arrangement with the sickness insurance funds. It is understood, but not necessarily adhered to by the physicians, that they are paid around three-fourths of a fee schedule set by the fund, with the patient paying the remainder.

Specialists are salaried employees, but they can maintain a private practice outside the hospital. Their patients are reimbursed for approximately one-half of the fee set by the fund. In recent years, private physicians, under the aegis of a corporation sponsored by the Swedish Medical Association, have been establishing specialist medical groups in the larger cities (Rosenfeld, 1969).

The physicians in Swedish group practice are on salaries, and the group collects fees from the patients in the same way as the general practitioners.

Equitable Accessibility of Health Care

When Sweden made medical care available to all at a price they could afford, the result was a shortage of medical facilities, something for which Sweden had not prepared. When the supply is limited to begin with

(and it was), conditions are exacerbated when everybody suddenly has access to total care.

To make the supply go as far as possible, Sweden has embarked on a crash hospital building program. The trouble is that waits in hospitals, except in an emergency, can be distressingly long. If a patient, for example, wants to consult a dermatologist at a hospital, it is not unusual for him to wait three months for an appointment.

Those who can afford it consult privately, of course. And for 'jumping the queue,' people are willing to pay more than the standard fee.

There is a special problem in the accessibility to medical care in rural areas to which it is difficult to recruit district medical officers. Sweden is attempting to deal with these problems by increasing the number of physicians and by encouraging them to practice in primary care rather than in specialities, but the problem of accessibility to care is far from solved. Options exist in the Swedish system as to direct access for patients to a range of physicians: a general practitioner, a specialist or a hospital polyclinic.

Even though the resources and the structures of the Swedish medical system are under pressure from patients and the funding sources are being pressed for more money, Sweden's underlying rationale in its medical care system is chiefly one of assuring access and less one of controlling cost, because of the decentralized nature of the financing. The national government sets the standards and contributes some monies, but it is up to the regions, the counties and the districts to provide the lion's share of the funds.

In conclusion, Sweden's medical care system, which of course is only one of the facts (and possibly not the most important one) for its excellent health status, has features that can be of interest to us for a number of reasons. It is a pluralistic system, which includes a mix of "public" and "private" ownership, more comparable to that of the United States in a number of its features than the system of other countries where the government is completely in control. It is an expensive system with more than 8 percent of the Gross National Product devoted to health services as in the United States. It is a decentralized system with a significant amount of local financing and therefore of local control of services, through the country councils and public health boards in local communities.

Additional factors contributing to Sweden's remarkably good health are: a high standard of living, low unemployment and a high level of technology, together with a stable ethnic population.

> Sweden has developed a medical system which is a strong and reasonably efficient and effective part of its health promotion and human service system. It contributes, though not as much as it could, to equity and community, and is one model for attempting to deal with some of these problems in a pluralistic, highly technological and highly professionalized society (Sidel, 1977, p. 128).

The very high tax rate in Sweden puts a very large price tag on its medical care. It makes a case against a National Health Insurance plan.

Chapter 3

Great Britain: Universal Eligibility Through Taxation

Great Britain is of special interest to us, because it is a society whose basic economic structure, values, language and culture are close to our own, and yet it is a society that chose to organize and pay for its medical care services in a way quite different from ours.

The British National Health Service, initiated in 1948, is based on the services of the general practitioner and emphasizes universal entitlement from the longest lived inhabitant to the newly arrived tourist.

The features of the British National Health Service that are most relevant to our discussion include: the elimination of financial barriers to access to all medical care, including private care; the efforts to provide medical care in a community context and to enable community members to participate more fully in the health care system; the continuing attempt to make the system and its impact more equitable; and, the preservation of a community based, primary care physician who provides accessible, integrated and continuing care for the ambulatory patient, usually on a family basis.

The development of health care in Britain has a very long and important history. International recognition has come to England over the centuries, not only for its pursuit of medical sciences, but for its advancement on a broad medical and social front which spread from

the providing of hospital care for the "deserving poor" to the protection of the child against the harshness of the industrial revolution. From the beginning of the nineteenth century, the voices of reformers spoke of the need for universal medical care, yet the first scheme of national health insurance was not introduced until 1911.

> That an ultimate solution to the problem of providing medical care would be a political one was clear to many from the beginning of the present century and the argument as to the form it should take went on continuously until the beginning of the National Health Services in 1948.
>
> The service itself has been praised by many who have studied it from the outside: it has been praised by people of Britain in the way in which they have learned to use it. It stands at the head of those European systems that attempt to be comprehensive and universal (Murray, 1974, p. 28).

The enactment of legislation establishing a national health service was assured by the 1945 election of a Labor government. During the initial planning stage, the consultant physicians, or specialists, were more receptive than the general practitioners, since they felt they had more power and more room to maneuver and since they were offered extraordinary fringe benefits, including the possibility of working part time on salary and part time for private fees. It is facetiously said that "the mouths of the consultants were stuffed with gold." The general practitioners were very much afraid of being placed on a basic salary and of being therefore reduced to the status of civil servants.

The general practitioners were persuaded to join the National Health Services by allowing them to remain "independent contractors" under a capitation system, rather than to have the status of salaried employees.

On the "appointed day," July 5, 1948, the British National Health Service Act was implemented. It guaranteed health care for all without charge at the time of care, irrespective of income level. Eleven thousand specialists and 18,000 general practitioners entered the National Health Service that day, against the advice of the British Medical Association (Rosen, 1974).

As far as its operation goes, the British system of national health care is unique. Unlike most other Western nations, it has jettisoned the insurance principle. The government simply pays for most of it, as one would for a postal system or a fire department. The way it works is as follows.

Every able-bodied worker must pay a weekly fee toward a complete social security package, as must his employer. The only people exempt from this are children, housewives, and old people. Since this pays only about sixteen percent of the total bill, the rest is paid directly out of taxes on such things as cigarettes, liquor and income. In return, people get almost total medical care, free at the time of the service.

> Individuals are free to register with a GP of their choosing, provided that the GP is willing to accept them on his list. The GP provides first contact and long-term continuing care; it has been estimated that the GP is the only point of contact for 90 percent of the episodes of ill health for which physician help is sought in Britain. Patients with 'major' or complex illnesses are usually referred for consultation and possible treatment to a specialist at the hospital (Fry, 1976, p. 5).

Let us now turn our attention to major topics on which we are comparing the four various systems.

Hospitals

Hospitals in England are divided into 15 regions, with a population base ranging from two to five million people. Each region has at least one teaching hospital as a referral facility for serious, relatively infrequent and complicated cases. The teaching hospitals are not part of the regional hospital governing body, but are a separate fiscal and administrative entity reporting directly to the Minister of Health and Social Security.

In each hospital region, the top governing body is the Regional Hospital Board. The members of the Board are appointed through joint consultations with the Minister and the parties at interest in the region and represent the usual range of constituencies: medical, dental, pharmaceutical, and prominent citizens. They serve without pay and carry great responsibilities, since they are in charge of reviewing the distribution, delivery and costs of hospital-based services and the maintenance, improvement and construction of hospital facilities.

There is general agreement that this hospital organizational structure has enormously improved the distribution of specialists. There is also general agreement among the public that even though few hospitals have been built since 1946, there has been an upgrading of hospitals so that the minimum standard is now higher than it might have been without a regionalized hospital system, although the very top quality may have been inhibited. The foregoing shifts have been made possible by central control over finances and then, within each regional board, control over allocations within the region.

On the minus side, hospital services are said by many to be seriously underfunded, with insufficient resources to rebuild and renovate buildings that in many cases are centuries old. Within the hospital system, regional inequities have also been permitted to persist. The London and Liverpool health regions have many more hospital doctors, longer lengths of stay and considerably higher hospital expenditures per person than do regions like Trent in the industrial midlands or more rural East Anglia and Wessex. In short, some of the inequities among regions which existed at the start of the National Health Service have continued over the twenty-five years of its life.

Patients are admitted to the hospital by consultants on referral from the general practitioners, usually from a waiting list, or directly from the hospital accident and emergency departments. In the hospital, the pateint becomes the responsibility of a "firm," which is made up of a consultant and of a number of junior doctors, the latter comparable in many ways to "residents" in the United States.

After discharge, the patient, in principle, again becomes the responsibility of his General Practitioner, although in practice there is often considerable overlap and at times confusion about responsibility for specific aspects of continuing specialty care. Lack of communication between GP and consultant is seen as a continuing problem.

Site of Practice of Doctors

A double pattern of medical care exists today in Great Britain, with specialists practicing in a hospital setting and general

practitioners conducting all of their practice on the outside, without hospital privileges.

General Practitioners provide primary medical care to those who are registered with them: they do not restrict their work to any special age or sex, disease or system. The General Practitioner provides first contact and long-term continuing care. Patients suffering minor or chronic illnesses will most likely be treated solely by the GP, while patients with major or complex illnesses are usually referred for consultation and possible treatment to a specialist clinic at the hospital.

The GP's office (or surgery as it is called) usually reflects the milieu in which it is situated and therefore varies markedly from area to area--from dingy, meagerly furnished storefront offices in the poorest sections of town, to modern, bustling, technologically well-equipped health centers.

British GPs have considerable leeway in organizing their work. They may provide their own premises, hire their own staff and equip their own offices. They may work singly, in two-person partnerships or in larger groups; the strong trend in recent years, however, has been toward working in groups. The GP may or may not work directly with non-physician personnel in the same premises, though the current trend, fostered by financial incentive, is to do so. More and more GPs are practicing in health centers, where the local public health workers join them in the care of patients from a defined geographic

district. Approximately 45 percent of all general practitioners today work in groups of three or more doctors. In groups, consultation with other GPs is readily available and a team approach to medical care is facilitated by having representatives of several different health disciplines under the same roof.

An unresolved issue is the remaining inequity of distribution of physicians (what Dr. John Tudor Hart, a general practitioner and articulate participant-observer in the NHS, calls the "inverse care law: the availability of good medical care tends to vary inversely with the need of the population served"). For example, while redistribution of general practitioners from overdoctored areas to underdoctored areas took place in the early years of the NHS, the redistribution had practically ceased by 1956, had gone into reverse by 1961, and between 1961 and 1967, the proportion of people in what are defined as "underdoctored" areas rose from 17 to 34 percent. Of the 169 new general practitioners who entered practice in underdoctored areas between October, 1968, and October, 1969, 164 came from other countries.

Furthermore, according to Hart:

> In areas with most sickness and death, general practitioners have more work, larger lists, less hospital support and inherit more clinically ineffective traditions of consultation than in the healthiest areas; and hospital doctors shoulder heavier caseloads with less staff and equipment, more obsolete buildings and suffer recurrent crisis in the availability of beds and replacement staff (Hart, 1975, p. 189).

Payment Mechanism of Doctors

> British GPs work basically for salaries paid by the health service. Only 20 percent of them earn

> income from private practice, too. Eight years ago, thousands of them protested bitterly over their salary levels and threatened to resign from the health service. But since then the rates have been changed. GPs now rank fifth among British salaried professionals, though their salaries are still low by U.S. doctor's standards (Lewin, 1971, p. 87).

The GP is paid by the National Health Service (NHS) through an annual capitation fee for each patient on his list; in 1975, the average list was approximately 2,300 patients.

In addition to the basic capitation payment for each person on his list, the contract agreed upon in 1967 gave the GP a higher capitation rate per patient if he has between 2,500 and 3,500 pateints, extra remuneration for each person over 65, for taking night calls, for maternity care, for family planning services, for working in groups of three or more physicians from common premises and for working in areas that are understaffed by physicians. In short, the incentives are intended to strengthen preventive services for everyone, to expand medical services for those least well served in the past, and to facilitate access to care.

The status of specialists under the National Health Service rose dramatically from their already high status prior to the implementation of the Act. Their fringe benefits--such as vacations, pensions, sick leave and, most important, the opportunity to earn distinction awards--significantly increase their income. They simultaneously exerted great influence and retained flexibility; many worked short of full time for the NHS and were therefore free to earn as much as they could in

lucrative private practice on their own time; they could even use Health Service facilities in the hospitalization of their private patients.

Today the income gap between GPs and specialists has somewhat narrowed,and GP's lifetime earnings can now exceed those of a full time NHS specialist. This change was fostered by many events, including the creation of a Royal College of General Practitioners which helped to increase the prestige of the GPs, the advent of health centers and of group practice and better salaries negotiated during the National Health Service reorganization of 1974.

Equitable Accessibility of Health Care

Despite its problems, the creation of the National Health Service

> represents a radical change in the relationship between the individual citizen and the State, and it established a firm government commitment to developing and improving the country's system of health care (Levitt, 1976, p. 17).

The major achievements of the Act are to provide medical care free of charge on the basis of need, rather than on the ability to pay, making medical care therefore accessible to everyone.

Community-based primary care and preventive services are an important part of the system. In addition to the general practitioner, a wide variety of health workers provides care in the community. Much of the work is done by medical and nursing staff who see patients at preventive clinics on a cyclic basis. Home health care is provided by home nurses to patients who need nursing care. Health visitors, who are nurses with additional specialized training in social aspects

of health education, also play a significant role in the provision of primary and preventive care. They are required to visit every mother after the birth of a baby and continue to observe the baby's development until it is five years of age. They also visit families to give advice on a wide variety of health matters and serve as a vital link between individuals and the health and social service departments.

Medical diagnosis and treatment are in the hands of the GP, most of whose work is concerned with common and minor illnesses, with little or no risk of loss of life or of permanent disability. A small percentage involves major illnesses, and these patients are usually referred for treatment to a specialist at the hospital. Although access to the GP is usually quite easy, one study showed that 75 percent of symptoms are treated by the patients themselves without going to see any doctor (Mariner, 1975). The average patient consults the GP four times a year; those who consult him more frequently tend to be the old, the young, people who live alone, and members of particular risky occupations, such as miners. If we add to the four visits to the GP the two visits per person per year to a specialist, it is clear that the fact that care is free at the time of use has not, as many had predicted, vastly escalated the demand for care. Quite the contrary, it appears that the rate of ambulatory physician visits in Britain is very close to the rate in the United States, where most of the visits involve direct payment on the part of the patient (Mariner, 1975).

In conclusion, the current British medical system has made health care accessible both from a financial and from a geographical point of view.

The fact that inequity of distribution still persists, with the poorest areas still remaining underdoctored, raises the question of whether health care in a society can be altered significantly without other radical political and social changes taking place as well (Hart, 1975).

In conclusion, public satisfaction with the system is seen, not only in the public opinion polls, but in the relatively small reliance on the private sector in medicine by those who could pay for it. Private health insurance plans and direct payment to private doctors indeed exist. In fact, there has been some increase in membership in private insurance plans in the last few years. But these are largely the results of industry offering this as a tax shelter and as a fringe benefit to managerial employees and not necessarily reflective of dissatisfaction with the NHS. Private practice is used largely for convenience--extra privacy or extra privileges--such as jumping the waiting list for minor medicine and surgery.

However, despite the great advance in equity and the preservation of a viable system of private care, serious problems continue to exist. One is that of the utilization and cost of drugs. At present in Britain, the doctor is free to prescribe any drug--except for hard drugs of addiction--at any dose level, for whatever period he chooses. Part of

the original assurance given in the formation of the NHS was that doctors would be free to exercise their clinical judgment. The only check on this freedom is that the number and cost to the NHS of all prescriptions written by GPs are monitored, and the practice of those who prescribe at a level considerably higher than the majority of other GPs is reviewed.

One problem, of course, lies in determining the cost of the drug. The pharmaceutical industry, totally in the private sector as in the United States and Sweden--but in contrast, of course, to the situation in the U.S.S.R. and China-- includes the high cost of research and advertising in the price of its drugs. Another critical issue is the distribution of resources within the system. The total expenditures in the hospital sector account for 65 percent of the NHS budget, while general practitioner services account for under 8 percent. There are nine times as many employees in the hospital service as in the community service. There is, of course, no doubt that even a brief inpatient episode is, by its nature, considerably more expensive than a visit to a GP, and that an outpatient visit also on the average requires more expensive technology and probably more personnel time than a GP visit. Nonetheless, the apparent imbalance between the investment and the number of people affected by the services suggests that there are powerful influences--based on the drama and the power of technology and of the consultants--which shift allocations toward the hospital sector.

Another of the critical problems which remain unsolved by the British health system is the continuing dissatisfaction of many of its

physicians. Now that a number of complaints of the general practitioners have been met, the situation of a few years ago has reversed itself and general practice is increasingly seen by students and doctors as a satisfying career. But among the junior hospital doctors, who are training to become consultants, there is dissatisfaction and considerable emigration. Many of them will have to wait for years, if not forever, for one of the limited number of consultant positions, particularly in surgery. Even among the prestigious consultants, there is, at times, the pull of extraordinary income or research grants in the United States or other countries wealthier than Britain.

Perhaps the best tribute to the National Health Service was made by an American, Don Cook, the London correspondent of one of America's leading conservative newspapers, who lived in England for some time and also received treatment under the health service. When he left, he wrote:

> An American cannot live in Britain today and see the Health Service at work without coming to a simple realization: what has been done here by democratic processes in a free society is a great step forward and an object lesson for democracy throughout the world (Cook, 1965).

In contrast to the United States, the British National Health Service is highly structured. Since it is almost entirely financed by the central government, the costs of the services are in direct competition with other obligations of the treasury. "Its Gross National Product was $3,800 per capita in 1975, compared to $7,900 in Sweden for the same period and $7,100 in the United States" (Oatman, 1978). Due to

limited funds, Great Britain has not been able to do more with its National Health Service, but has still been able to deliver comparatively equitable health care. It is my contention that Great Britain provides medical care of high technical quality distributed much more equitably than in the Britain of 1948 or in the United States today. It is an example for the United States to consider.

Chapter 4

Soviet Union: Maintaining the Productivity of the Working Class

The Soviet Union covers one-sixth of the earth's surface and extends over almost three times the land area of the contiguous 48 United States. It is in land area the largest nation on earth. Its population of 255 million is approximately sixty percent urban and is extremely unevenly distributed. Vast areas which are very sparsely populated are counterbalanced by heavily populated areas which have urban and rural population densities as great or greater than those of the United States. The ethnic breakdown of the Soviet Union is also highly diversified: just over 50 percent are "Russians," while the other 50 percent is composed of over 100 nationality groups such as Ukrainians, the Uzbeks, the Belorussians, the Tartars and the Kazaks.

> The Soviet Union's industrial productivity has risen rapidly over the past 60 years. The Gross National Product per capita in 1975 was $2,600; despite its rapid rise, however, it is still considerably lower per capita than that of the United States, Sweden or Britain. Because its means of industrial production are almost entirely government-owned and administered, the Soviet Union has far greater control over all of the elements of its economy than does any of the societies we have discussed so far. Also, its planning and management are considerably more centralized than are those of the other countries (Sidel, 1977, p. 158).

The Soviet Union's health care system is of interest for several reasons. It provides health care totally free of charge at the time of need to its entire population. It is also a government-operated,

centrally planned system which functions as an integral part of a planned economy. In addition, it trained vast numbers of physician workers, and consequently has the highest ratio of health workers to population of any country in the world. It has also given high priority to services for special groups such as mothers and children and industrial workers, services which in the United States are particularly fragmented and weak.

The historical background of Soviet medical care is as fascinating, poignant and tragic as the rest of its history. Until the middle of the eighteenth century, the practice of medicine and medical research remained largely in the hands of foreigners, most of whom did not speak Russian. As diplomatic and commercial contacts between Russia and the West intensified in the sixteenth and seventeenth centuries, more western European physicians (from England, Holland, Germany and France) came to Moscow, there to serve the court and the Tsar. They were well remunerated and, provided they did not dabble in politics, could expect to return home as men of considerable wealth. The demand for physicians, and particularly military surgeons, increased during the seventeenth century because of the growth of the army, warfare in southern Russia, and the drive toward the Baltic Sea.

> Many of the foreign regiments that served in Russia would not fight without surgeons. These surgeons were, however, no longer the personal servants of the Tsar or the court, but rather the servants of the state, hired to provide medical and surgical services to a designated group of individuals. Employment of physicians as state employees became firmly established as a result of the

> growing need of the state, and particularly of the armed forces, and has remained the predominant pattern to this day. This may be contrasted with the development of medical practice in North America, where the predominant and culturally approved pattern has tended to be that of private practice (Field, 1967, p. 16).

Peter the Great (1696-1725) laid the foundation for scientific work by importing scientists, books and scientific collections from Europe, including many relating to medicine, and by suggesting the foundation of an Academy of Sciences.

Another important milestone was the founding of Moscow University in 1755; a medical faculty began functioning in 1764, and in the years that followed many distinguished medical men were among its members. Russian medicine became therefore, finally, part of the mainstream of European medicine. But it was not until the nineteenth century that Russian medicine truly came of age, as a result of the general flowering of culture and scientific life and increased contact with the West which followed the Napoleonic Wars.

From the social point of view, it also was not until the nineteenth century that the vast majority of Russian people--the poor who lived in towns and the entire rural population--had anything in the way of medical care aside from folk medicine. There were, of course, earlier hostels and asylums for the indigent sick which were maintained by churches, particularly by monasteries.

Health conditions among the urban workers and the peasants were deplorable; the high illness rates prevalent in "normal times" were compounded by intermittent epidemics and famines which swept through

the country. In the development of medical care, as we have seen, Russia trailed long behind Western Europe. Most physicians practiced in the cities, treating the middle and upper class urban population and leaving the care of the peasants and workers to folk healers and to health workers with very limited training.

> An important feature of the development of Russian medicine and medical organization in the nineteenth century were the Zemstvos created in 1864, as part of the reforms introduced after the Emancipation Proclamation which freed the serfs. The reforms aimed at a partial decentralization of governmental operations, reduction of the power of the bureaucracy and the development of limited local self-government in the countryside. Similar self-government units were established for the towns. Zemstvo functions were broad and diversified, embracing such local activities as road building, supervising prisons, education, public welfare, social assistance and medical care and public health (Field, 1967, p. 20).

Zemstvo medicine was the first attempt to meet Russia's enormous health problems, to provide organized medical services to the rural population and to regionalize medical care through the use of defined geographic districts. A significant factor in the nobility's willingness at this particular time to provide medical care to the urban poor and to the rural population was a belief, imported from Western Europe, in the theory of infectious disease and the effectiveness of hygiene and medicine in controlling disease. The nobility came to realize that they could not be insulated from the disease around them, that their health was, in part at least, dependent upon the health of all (Hyde, 1974).

The Zemstvos developed two types of health care systems: a "touring system" in which health personnel traveled around the district from village to village seeing patients, usually on market days; and a "stationary system" through a network of dispensaries, or outpatient clinics which were supposed to provide basic primary care. In principle, the dispensaries were to be staffed by district doctors, but in practice they were too poor to afford doctors and most of them turned instead to "feldshers" and midwives.

The "feldsher," a kind of assistant doctor introduced into the army by Peter the Great, was given usually little more than brief, on-the-job training, but was required, in the absence of more formally trained physicians or other personnel, to deal with the entire range of medical care problems.

Health insurance, which had developed in Germany in 1883 under Bismarck, was spreading to the other European countries. In 1905, a petition that the St. Petersburg workers tried to bring to Tsar Nicholas the Second's Winter Palace, carrying icons and portraits of the Tsar, their "Little Father," as they marched--had included a demand for social insurance. The Tsar's troops fired on them, and 130 were killed. "Bloody Sunday," as it was called, led to the establishment of a legislative assembly, the Duma.

In 1912, under the influence of the Health Insurance Act introduced in Britain in 1911, the Duma passed a social security law establishing a factory hospital fund financed from contributions from

employees and employers. The fund would provide hospital and outpatient care for workers who suffered work-related accidents or illness, and also pay some other expenses for them and their families. The provisions, however, covered only one-fifth of the total number of workers, and there was no provision at all for invalids, the elderly or orphans. Furthermore, in practice the law really only covered outpatient services, and even this coverage was discontinued at the time of the outbreak of World War I in 1914.

As Russia entered the war, medical care by fully trained physicians was still a privilege largely confined to the rich and powerful; rural medicine was still in a rudimentary state; the central medical authority barely functioned and elements of public health were administered by no fewer than eleven government departments.

> The infant mortaility rate for the period 1900-1914 was about 250 deaths in the first year of life per 1000 children born alive; in other words, one child in four failed to survive to its first birthday. Both these figures were approximately double the rates for England and Wales for the same period.
> Thus, in 1917 the Bolsheviks inherited a corrupt, economically bankrupt country with major health problems and indadequate medical care resources. It was a country on the verge of military collapse, weakened by epidemics and by lack of food (Sidel, 1977, p. 168).

On November 13, 1917, a few days after the Revolution, the Soviet government issued a decree calling for comprehensive health, disability and unemployment insurance. Because of the Civil War and the disorganization which resulted from it, it was not until 1922 that it was possible to establish social insurance in such a large-scale, uniform way. During this organization period, there was considerable conflict

between the medical profession and the Bolshevik leadership. One element of the conflict centered around the Bolshevik's belief in the importance of making medical service available on a priority basis to those who had received the least medical care prior to the Revolution. This policy conflicted, according to the physicians, with the ethical universalism of medicine. Another critical issue was that of reducing the status of physicians to that of workers, who with their authority considerably decreased, would be considered the equal of all other medical workers.

The period from 1928 to 1941 was one of extraordinarily rapid industrialization, collectivization and urbanization. Massive investments in health service, especially in clinical medicine, accompanied and aided this transformation of Soviet society.

During this period of intense, rapid industrialization, the "productive" sectors of the economy were given far higher priority than the "non-productive" service sector; and women, the last to enter the labor force, became predominant in the "non-productive" sector, such as the health field. In other words, by recruiting women into medicine, the Soviets were freeing men for heavy industrial labor. By the way, the trend has continued and, whereas in 1940 sixty percent of all physicians were women, by 1974 the number had risen to seventy percent.

During World War II, the Soviet Union suffered immense losses of medical manpower, facilities and equipment and yet, because the training of medical personnel was increased during the war, there were more physicians in the Soviet Union in 1946 than before the war. Primary

emphasis was given to the care and treatment of sick and wounded soldiers, but special attention was also given to the health of women and the care of their children since, with the annihilation of vast numbers of working age males, women now comprised a large part of the civilian labor force.

> Today the USSR has the highest number of physicians per unit of population of all countries. Medical care is available to all the 230 million citizens of the USSR free of charge and great efforts have been made to distribute care even to the most rural areas. Essentially doctors are trained as specialists, so that the primary care physician is a specialist in that field and has selected that field quite early in his training. Every doctor is trained in prevention and indeed the greatest emphasis in health propaganda is on prevention. When one recalls the great epidemics from which Russia once suffered, one can accept that to reach health statistics comparable with other parts of the advanced world, as she has done, great preventive campaigns have had to be carried through (Murray, 1974, p. 41).

We shall now turn to our four major areas of concern on which we are comparing the various systems.

Hospitals

In 1974, the Soviet Union reported almost three million hospital beds or 12 per 1,000 people. Hospitals are regionalized and range in size and service from small inpatient units attached to outpatient clinics, to large district, municipal, regional and specialty hospitals. The specialty hospitals include those for maternal and child care, for cardiovascular diseases, tuberculosis, cancer and venereal disease.

Urban primary care services are provided in district polyclinics. In general, the adults of the district go to an adult polyclinic and the children to a pediatric polyclinic. No specific method for

coordinating the care of a single family is built into the system, except in cases of certain types of infectious disease.

Polyclinics deal with 80-85 percent of all episodes of illness from beginning to end. The adult patient may either first see the primary care doctor or refer himself to a specialist in the polyclinic; both are considered first contact physicians. The primary care doctor may, of course, refer the patient to a polyclinic specialist or, when necessary, directly to a hospital-based specialist. Children's polyclinics are similarly staffed by primary care pediatricians and pediatric specialists (Field, 1967).

Hospital facilities in the rural areas are regionalized and are of three types: intercollective farm hospitals, district hospitals and regional hospitals. For more isolated rural areas, primary care is provided by feldsher-midwife stations. The health care provided by them includes epidemic control measures, reduction of childhood morbidity and mortality, early case finding, observation and medical services for tuberculosis, malignant tumors and other diseases, sanitary measures to improve the living and working conditions of the people engaged in farm production, and health education. While in the cities, the feldsher generally works under the supervision of a physician, in the rural areas he practices relatively independently of the physician except for regular supervisory visits.

The organization and provision of primary care in the rural areas of the Soviet Union have been hampered by the large differences in population density among the fifteen republics, with the Republic of

Moldavis, for example, having a population density of 103 per square kilometer, while the Republic of Turkmenia on the Caspian Sea having a population density of four persons per square kilometer, which makes it the most sparsely populated republic in the USSR. Significant differences in resources and wealth also exist among the republics, the least industrialized being the poorest.

An interesting item is the so-called "closed system of paying polyclinics" which provides specialist services for a small fee to members of the Soviet political and cultural elite and to their families.

This blatant departure from equity appears to be an exception to a system which strives to be just and equitable to all citizens.

Site of Practice of Doctors

With 700,000 physicians, the USSR has more physicians than any other country, both absolutely and--with one for every 350 people--relative to population size. The doctors are not, however, evenly distributed according to the numbers of the population. They range from one for every 500 people in the Tadzhik Soviet Socialist Republic to one for every 250 people in the Georgian S.S.R. Many young physicians are sent to underdoctored areas for three years after the end of their training, but there is considerable resistance on their part to remain in the rural areas. Rural medical schools are being established as part of the attempt to increase the number of doctors in rural areas (Sidel, 1977).

The Soviet Union, however, has not managed to solve the problem of persuading medical personnel, particularly physicians, to work in the

rural areas, and consequently there is both a shortage of doctors in the countryside and a rapid turnover of those who do go to work there.

Since the beginning of the industrial revolution, there has been a heavy emphasis in the Soviet Union on the maintenance of the working capacity of its industrial workers. In factors with 4,000 or more workers, industrial medical departments provide a wide range of services including specialist, outpatient and inpatient treatment, as well as industrial hygiene. In addition, all coal mining, oil refining, oil extracting, ore mining and chemical plants with 2,000 or more workers are eligible for a department. In addition to providing treatment, industrial medical departments are responsible for occupational accidents and diseases, mass screening for tuberculosis and cancer, and the containment of infectious diseases.

> Workshop doctors, often assisted by volunteers called 'health activists,' are crucial pivots in the Soviet industrial health system. The doctors have an intimate knowledge of their workshops and are responsible for such occupational health elements as protective clothing, workshop ventilation, dust content and noise levels.
>
> Another significant aspect of Soviet industrial health services are health resorts and sanatoriums, which have been an important element of health care in Russia since the early 18th century.
>
> Finally, of particular interest are the special institutes and hospitals for occupational illnesses in each republic. These institutions concentrate patients with occupational diseases together with physicians and researchers who have special competence in the field, thereby providing a focus for continued emphasis on occupational health (Field, 1967, p. 135).

As mentioned earlier, urban primary care services are provided in district polyclinics. However, there is a great emphasis on seeing the patient in the home. The microdistrict covered by a polyclinic

physician is usually geographically quite small, so that patients are all located either within walking distance or a relatively short automobile ride from the polyclinic. Generally, all of the adults living within a given apartment building or within an area of a few blocks are patients of the same physician; in fact, records in the polyclinic are filed by address rather than by patient's name. The physician usually spends from one to two hours a day visiting the apartments of patients in the microdistrict.

The hope, of course, is that one doctor will provide continuous medical supervision of the same group of people over a prolonged period of time and that the doctors will become familiar with the area, the patient and the social conditions. However, reports of overworked medical personnel, high staff turnover and the difficulty of retaining doctors in primary care continue to persist. In some polyclinics, not all of the positions are filled and some doctors work one and a half shifts.

As I just mentioned, the Soviet Union is having difficulty keeping physicians in primary care. The lure of specialization, and its greater status and material rewards, frustrates Soviet attempts to provide comprehensive, continuous primary care to the entire population, both urban and rural.

Payment Mechanism of Doctors

Physicians are salaried, as are all health personnel, and there is a distinct hierarchy with large differential increments in pay for

length of service and for more specialized or higher administrative positions.

In 1974, seventy percent of all Soviet physicians were women. This is an outstandingly high percentage compared to other countries. However, a large number of women physicians are in relatively low-status positions. Polyclinics, the site of primary care in the cities, have six and a half hour work shifts, which combine well with the homemaking role most Soviet women still play. Male physicians often work one and a half or even two shifts, with concomitant higher pay, but such long hours are frequently impossible for women.

Middle medical workers include feldshers, nurses, midwives and pharmacists. Soviet health authorities have had varying views of the feldsher over the years. At first, the Soviet Government decided that the institution of the feldsher should be abandoned, since "feldsherism" was considered second class rural medicine and the government wanted to equalize care between urban and rural areas. But the need for health personnel became so great and the problem of recruiting physicians for the rural areas so difficult, that by the late 1920s and early 1930s, the schools for training middle medical workers were increased in number, expanded and reorganized and resumed their training of feldshers.

> Today the feldsher holds the place in society of one who graduated from a 'technicum'--a secondary vocational school--rather than an institute or university. He is in the position of the technician as compared to the engineer, or the draftsman as compared to the architect. Reports vary, but the beginning feldsher appears to earn between 70 and 90 percent of the salary of the beginning physician. The salary is higher, as it also is for the physicians, if the feldsher is in a rural area and in a position of greater

> responsibility (for example, head of a feldsher-midwife station). The feldsher's salary increases with years of experience and, after a few years, he is earning more than the initial salary of the physician.
>
> Unlike the Chinese barefoot doctor, who is considered a peasant and works as a medical worker part time and as an agricultural worker part time, the feldsher is a full time medical worker who does not consider nonmedical work part of his job (Public Health Paper, 1974, no. 56).

The new revolutionary government may have hoped in 1917 to change the status of doctors so that they would be considered and would consider themselves another group of workers, but they have not succeeeded. The hierarchy among doctors and among all health personnel from financial and other points of view remains sharp and clear, and there is no evidence of change at the present time (Kaiser, 1976).

Equitable Accessiblity of Health Care

As mentioned before, there has been a heavy emphasis in the Soviet Union on industrial health services. It was clear to the Soviet leaders that high productivity would depend on the good health of industrial workers. Today, approximately thirty percent of the people of working age receive their health care and medical care through a special network of health services in the industries in which they work. In hazardous industries, such as the oil and mining industries, a physician's health station is set up if there are over 500 workers. In non-hazardous industries of modest size, there is usually a health station staffed by non-physician personnel. The doctors make routine tours of the workshops and, if stationed in isolated areas, they may provide care for the surrounding population as well.

Along with the extensive medical network serving the industrial workers, health care services for the community and for the individual appear to be highly accessible and range from primary care to super-specialized services, from tiny rural health stations to huge city hospitals.

However, problems of extreme overcrowding in polyclinics and hospitals, of doctors spending their time doing paper work rather than seeing and treating patients, and of vast variation in quality are reported both by some Soviet sources and by Western reporters. Because of long waiting periods, reports of black market payments to workers in the medical care system come to the surface repeatedly (Navarro, 1977).

We might add to this the severe shortage of doctors willing to work in rural areas, as mentioned earlier.

> The Soviets have stressed the importance of developing a nationwide health system, yet their coverage of rural areas is far from optimal (Ginzberg, 1977, p. 71).

Care for patients with chronic illness is provided through special facilities in a process called "dispensarization." There are, for example, dispensaries for cardiovascular disease which serve several polyclinic districts and more specialized ones at the city level. Patients are encouraged to see the specialist regularly, in addition to the general medical care provided at the polyclinic.

Primary care in cities can also be obtained by going directly to the emergency room in a hospital or by telephoning "03" from pay telephones at no charge for the call, and no coins are needed.

A critical examination and assessment of the Soviet experiment will yield important lessons to be learned by those concerned with health and the planning of medical services in other countries. The Soviet Union remains to this day the world's only major power to have made health care and medical care completely free and largely accessible and equitable to its people at the time of need. A vast commitment of manpower and other resources was needed to accomplish this herculean task: it should be recognized by the rest of the world as one of the more impressive and positive achievements of the Soviet regime.

In conclusion, the Soviet Union has no doubt created a comprehensive national system of health protection and medical services that might well serve as a blueprint for any modernizing nation. Starting with very limited resources in facilities and personnel at the time of the Revolution, the regime proceeded to expand these resources at a rapid rate. There is no doubt that, overall, the health system has fulfilled its mission satisfactorily at least on a quantitative basis. The choice for quantity as opposed to quality was a wise one, since a quality approach under the circumstances would have not only been too costly but also unrealistic.

Despite many problems (which the regime cleverly attributes not to itself or to its system of socialized medicine, but to the personal negligence of some health personnel), the Soviet citizen finds in socialized medicine at least some evidence of the regime's concern for his health, his well-being and the welfare of those who are dear and close to him.

> Despite its shortcomings, the challenge posed by Soviet socialized medicine to the West and particularly to the United States is imposing. There is, first, the obvious challenge of the contribution medicine and public health make to Soviet power and potential by raising the health level, the vitality and the longevity of the population. Further, at the political and ideological level the challenge might be formulated as follows: In the world situation today, because of the absolute nature of contemporary weaponry and the assurance of mutual suicide in the use of these weapons, the struggle for men's minds, loyalty and allegiance between East and West takes more and more the form of what each system can offer to the people. It is in this respect that the Soviet blueprint of socialized medicine dispensed as a public service has broader ideological appeal, particularly to the underdeveloped countries of the world, than the more sophisticated, mixed private and public American model (Kimbrough, 1975, p. 230).

There is no doubt that the countries of the Third World are impatient to solve their health problems (which slow down their economic and social development) and that, if asked, the Soviets will be glad to assist and advise in these matters.

> Equally disturbing is the rate at which physicians are being trained in the Soviet Union, compared with the United States, and the fact that from 20 to 25 percent of all the world's doctors today are Soviet doctors. The USSR, if it so chooses, soon will be able to export physicians to the underdoctored areas of the world; it has already done so on a limited scale. In the second half of the twentieth century, the medical missionary appears likely to replace his religious colleague of yesterday as a means of peaceful penetration. It may be noted that the United States finds itself in the embarrassing position of having to import large numbers of physicians trained abroad to staff its hospitals, thereby further depleting the already meager medical contingents of some developing countries, such as India (Kimbrough, 1975, p. 231).

Despite the books and articles published on the subject of Russian health and medical care today, it is very difficult for anybody to truly assess its overall merits. This is due mainly to the lack of candor

which characterizes the rapport between Communist countries and our own. It seems apparent though that in the area of mental health, the Russian government often uses its system of medical care as a political tool of the state to suppress and constrain its dissidents (Thorne, 1977). This casts a disappointing shadow in an otherwise very positive achievement of the Soviet regime.

Chapter 5

The People's Republic of China: How to Turn Medical Care Into a Political Issue

In order to understand and assess China's medical and health care today, we must first examine the nation itself, from the point of view of its geography, the development of its technology, its history and the life of its people.

China's mainland territory, an area almost exactly the same size as the United States, is the home of what is by far the world's largest population, an estimated 850 million people. Of its land area, however, only a relatively small part is arable. Therefore, China must feed approximately 20 percent of the world's population with only 8 percent of the world's cultivated land.

China's population is, furthermore, most unevenly distributed. The vast majority of the people live in eastern China, with its three great river basins; western China, with its mountains and deserts, is exceedingly sparsely populated. The four least densely populated sections--Inner Mongolia, Sinkiang, Tsinghai and Tibet--comprise just over half of the area of the country, but contain less than 4 percent of the population. In addition, some 80 percent of the Chinese people live in rural areas, an almost exact reverse of the population distribution in Sweden, Britain and the United States, and a far larger proportion of rural population than that of the Soviet Union.

China is a poor country by the standards of the countries examined previously. China's Gross National Product per capita is one-thirtieth

that of the United States. More specifically, China, with almost four times as many people, produced one-thirtieth the electric power and one-seventh the crude steel produced by the United States. In agriculture, labor-itensive rather than mechanized methods are used (Sidel, 1973).

China's health services have thus had to deal with the needs of a vast country and an even greater population, predominantly rural, unevenly distributed, and extremely poor in material goods compared to the people of the technologically developed countries.

> While statistics are just not available on the current health status of all of China's population, visitors in the 1970s report a nation of healthy-looking, vigorous people. There does not seem to be evidence of the malnutrition, ubiquitous infectious disease and other ill health that accompanies poverty in most other countries of the world and was so prevalent in China up to 30 years ago.
>
> The reports from visitors seem uniform to confirm the success of the Chinese health system in terms of problems which could be labelled "public health." The cleaning up of canals, irrigation ditches, gutters, ponds, rivers, courtyards and houses is not exactly medical care as we think of it in the West, but such measures were an essential step in getting vermin, lice and disease spreading pests under control. The use of boiled water and the mass assault on veneral disease, leprosy, ringworm, malaria and tuberculosis have either eliminated these diseases or contained them. Adequate food has wiped out one of the greatest scourges of old China, famine and starvation. Good nourishment has stopped rickets, good midwifery has stopped high infant and mother mortality (Dimond, 1975).

These changes in health status are certainly not only the result of changes in medical care or even in health care; improvements in nutrition, sanitation and living standards are at least as important. But changes in medical care have undoubtedly also played an important role.

Among the elements of the health and medical care system in China which are of special interest to the United States are: 1) the society's

fundamental redistribution of wealth and power, which makes possible many of the elements in the system; 2) the system's emphasis on preventive medicine; 3) its utilization of traditional Chinese medicine in combination with "Western" medicine; 4) its training of part time health workers who remain integral members of the community; and 5) its attempts to mobilize the mass of people to protect their own health and the health of their neighbors.

> In Shanghai and Peking, China's largest cities, health statistics are now becoming available to Westerners. Data for Shanghai City proper show an infant mortality rate of 12.6 per 1000 live births (comparable to Stockholm and far lower than New York City's 18.1 per 1000 for white babies and 12.6 per 100 for 'non-white' babies.) The life expectancy in Shanghai City now appears to be about 70 years and the leading causes of death to be cancer, stroke and heart disease. While Shanghai is not representative of the rest of China, or even of its other large cities, the remarkable changes over the past two decades in Shanghai--the infant mortality rate in 1948 was estimated at 150 per 1000--are probably indicative of rapid changes in health status throughout China (Sidel, 1977, p. 188).

There are two distinct streams of medicine in China: Chinese and Western. Chinese traditional medicine is probably the world's oldest body of medical knowledge, having a history of several thousand years of empirical observations and complex theory. Diagnostic methods include observation and questioning of the patient and detailed and prolonged palpation of the pulse; therapy makes use of medical herbs, breathing and gymnastic exercises and acupuncture.

The Chinese traditional medical system, similar in many ways to the thinking of the ancient Greeks and Arabs, is based on a belief in the relationship between macrocosm and microcosm and in the observation.

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and classification of the properties of natural products. The traditional medicine that flourished in China throughout the centuries led to a wealth of empirical observations; among them, the discovery of the circulation of the blood, almost 2,000 years before its discovery in the West. Chinese traditional medicine discovered the fundamentals of smallpox inoculation in the middle of the sixteenth century, and it was not until 1798, over a hundred years later, that Jenner published his observations on cowpox inoculation for the prevention of smallpox in the West.

Physicians were first appointed to the courts of the grandees during the fourth century B.C. The primary responsibility of government physicians attached to the courts was the examination of the numerous personnel of the palace and the early detection of disease; they were also responsible for food control and general hygiene. Thus, the Chinese emphasis on prevention is not purely a contemporary phenomenon, for traditionally the physician who knew how to prevent disease was more highly respected than one who waited until the patient was sick.

Schools of Western medicine were established in China during the late nineteenth century and the early decades of the twentieth century but, while in the cities the status and prestige of Western doctors increased relative to that of traditional doctors, there were far too few of them to meet the needs of the people, especially of the poor (Palos, 1972).

There is common agreement that prior to 1949, the date of the formal assumption of state power by Mao Tse-Tung and the Chinese Communist party (an event the Chinese people refer to as the

"Liberation"), the state of health of the vast majority of the Chinese people was extremely poor, and the health services provided for them were grossly inadequate.

> The people of China in the 1930's and 1940's suffered the consequences of widespread poverty, poor sanitation, continuing war and rampant disease. The crude death rate was estimated at about 25 deaths per 1000, one of the world's highest. The infant mortality rate was about 200 per 1000 live births; in other words, 1 out of every 5 babies born died in its first year of life (Quinn, 1974, p. 75).

Most deaths in China were due to infectious diseases, usually complicated by some form of malnutrition. Veneral disease was widespread. Nutritional illnesses included most known forms of total calorie, protein and specific vitamin deficiencies, including beriberi, pellagra and scurvy. Malnutrition was often a euphemism for starvation.

The bulk of the medical care available to the people of China was provided by the roughly half million practitioners of traditional medicine who ranged from poorly educated pill peddlers to well-trained and widely-experienced practitioners of the medicine the Chinese had developed over two millennium. These practitioners, and those who practiced Western medicine remained deeply mistrustful of each other and blocked each other's efforts in many ways. Probably most important of all, three-fourths of the Chinese people were said to be illiterate. Feelings of powerlessness and hopelessness were widespread; individual efforts were of little avail,and community efforts were almost impossible to organize.

Following Mao's takeover in 1949, all efforts to provide health services were expanded into a new national policy. According to this

policy, medicine was supposed to serve the needs of the workers, the peasants and the soldiers, those who had previously had the least services rendered. Preventive medicine was to be put first--that is, where resources were limited, preventive medicine was to take precedence over therapeutic medicine. Chinese traditional medicine was to be integrated with Western scientific medicine: instead of competing, the practitioners of the two types of medical care should learn from each other. Health work was to be conducted with mass participation. Everyone in the society was encouraged to play an organized role in the protection of his own health and that of his neighbors.

A number of new medical schools were established, some of the older ones were moved from the cities of the east coast to areas of even greater need further west, and class sizes were greatly expanded. It has been estimated that more than 100,000 doctors were trained over fifteen years, an increase of some 500 percent.

At the same time, large numbers of middle medical schools were established to train assistant doctors (nurses, midwives, technicians and pharmacists). In addition to these efforts to rapidly produce many more professional health workers, people in the community were mobilized to perform health-related tasks themselves.

The Chinese approach to these massive health drives has been to politicize the issue. Instead of delegating the specific health problem to the health departments or to the individual doctor or community hospital, as we have done for example with alcoholism, the Chinese government made the problem a national issue related to patriotism, citizenship and duty to the country. The elimination of venereal

disease, for example, was declared policy of the Communist Party and, therefore, there was no debate or individual latitude. The straightforward message was that good citizens do not have venereal disease.

> The same approach has been used for the elimination of narcotic addiction. The clear public policy of absolutely not tolerating the further use of narcotics within China was given a specific cut-off date and was reinforced by constant newspaper and radio coverage. In February 1950, Chou En-lai issued a directive forbiding growing, manufacturing, selling and using opium. Anyone selling narcotics would be arrested. If, after such persuasion, the offender continued to sell narcotics, he was subject to being shot. Anyone addicted to narcotics would be helped to free himself and would have employment.
>
> The same sequence was followed in the elimination of prostitution. A date was declared, all houses were closed and rehabilitation programs were begun, frequently on the premises. Education for new careers was immediately begun. Many prostitutes were resettled into new jobs and factories or returned to their families in the countryside (Dimond, 1975, p. 131).

Using the techniques of mobilizing the entire country to wipe out venereal disease and narcotics, as well as diseases such as smallpox, cholera and typhus over the span of only one generation, was a truly monumental feat.

However, in spite of Mao's urgings and the efforts of propaganda, there was still considerable resistance on the part of higher medical graduates to practice in rural areas where there was the greatest need for them. As a result, by the mid-1960s, much of the large rural population still lacked adequate access to medical care.

With the help of editorial writers, especially in Shanghai, Mao began hammering at his own Party, and by instigating the Chinese youths, launched his Great Proletarian Cultural Revolution and was able essentially to close down the Party, purge it and rebuild it.

The actual violence of the entire three year purge is beyond any measuring stick which we Americans can apply. Ninety percent of the cadres were removed and retrained or replaced. All universities and colleges were closed. All Foreign Office representative but one were called home.

Medicine, one of the large units of any society, was a prime target of the Cultural Revolution. Every medical, pharmacy, and dental school was closed. All students in school were declared "graduated" and sent to the countryside to practice indefinitely. The message was summarized in three words: "Serve the People." Persuasion had been tried from 1949 to 1966,and the medical teaching institutions and specialty hospitals had misunderstood the message. The big special hospitals in the cities were equal to any in the world. By their standards, they had "served the people" and served them well.

However, most of the Chinese people were not living in these cities, and most would never be served by these special skills, excellent though they might be.

China was not cities, and big city medicine was not useful to a land-tied peasant. Serving the people meant that medical care had to be produced in the countryside--now. Through coercion, through demand, programs were initiated at once which kept one-third of the hospital's personnel, from doctor to janitor, in the countryside at any one time (Gibson, 1972).

A new health care professional was created who was a working peasant with only three to six months of training as a first aid worker and the

colorful title, "barefoot doctor." There are now said to be two million of them in China. He is neither barefoot nor a doctor, but is the in-residence neighborhood first aid man or woman, ready to give and equally ready to carry out the national rules.

As a result of the Cultural Revolution of 1966-69, much in medicine was markedly reorganized. Higher medical schools began to admit students who had less previous schooling but had the experience of working in factories and in communes. The curriculum was restructured to place greater emphasis on practical rather than theoretical aspects, with much more training in traditional Chinese medicine and was reduced to three and a half years instead of six as previously.

We will now briefly explore the Chinese system of medical care, according to the four areas of concern: hospitals, site of practice of doctors, payment mechanism of doctors and equitable accessibility of health care.

Hospitals

Marked advances have been made in the area of hospital care since the Revolution. Hospital facilities in China in 1949 were extraordinarily inadequate; the maximum estimate of the number of hospital beds in 1949 was 90,000, less than one bed per 500 people. Furthermore, hospital beds were concentrated, as were the doctors, in the cities. It has been estimated that some 860 new hospitals averaging 350 beds were built between 1949 and 1957. This amounts to one new hospital completed somewhere in China every three and a half days--a total some 300,000 beds in eight years (Wilenski, 1976).

Hospitals in the cities range from small neighborhood hospitals, similar to American neighborhood health care centers, which care only for ambulatory patients, to technologically sophisticated research and teaching hospitals. In Peking, for example, above the neighborhood level there are four research-oriented and specialized hospitals operated under the aegis of the Academy of Medical Services; 23 municipal hospitals, 10 of which have over 500 beds, under the jurisdiction of the Peking Bureau of Public Health; and 20 district hospitals.

The Shoutu (Capital) Hospital, formerly the hospital of the Peking University Medical College, was called the Fanti (Anti-imperalist) Hospital from the onset of the Cultural Revolution until early 1972 when it was renamed again.

Municipal hospitals have jurisdiction over the health service in a given geographical area, including those provided by factories, schools, local health stations and district hospitals. They also have responsibility for a segment of the surrounding rural area and send mobile medical teams to the countryside to provide services and to train local health workers.

In the rural areas, many large communes have their own hospital facilities to which patients are referred from the production brigade health station. In the ten rural counties that are part of the Shanghai municipality, for example, there are 212 commune hospitals, with an average of 30 beds each (Sidel, 1974). Commune hospitals are locally administered and financed. County hospitals, which are generally located in the towns and serve the people of the surrounding areas as

well as those referred from the communes, are larger and far better equipped than commune hospitals.

There is no doubt that, by our standards, the "surroundings" of hospital care in China today would be totally unacceptable. But if we look beneath the trappings and consider the qualities of availability, relative cost and effectiveness, the Chinese have produced a model solution to their problem.

> Although the equipment in the neighborhood hospital is sparse and primitive, it seems adequate for the level of health work performed there. The institution appears to function at a level not unlike that of many neighborhood centers in the United States, one difference of course being the great use of traditional Chinese medical techniques (Sidel, 1974, p. 51).

Site of Practice of Doctors

The Cultural Revolution brought about great changes in medical practice. Previously, some mobile health teams had traveled the countryside providing services and training, but now mobile medical teams were organized on a massive scale.

Part of their responsibility was the training of large numbers of barefoot doctors, peasants who provide elements of sanitation, health education, first aid and primary medical care, while continuing their farm work. The term "barefoot doctor" stems from the fact that much of the work in rice paddies is done barefoot.

The barefoot doctors usually work in health stations at the production brigade level, but do much of their work, both medical and agricultural, with their fellow members of the production team.

Health workers called "worker doctors" are analogous to the barefoot doctor and work in urban factories. They provide preventive medicine, health education, first aid, occupational health services on the factory floor and the factory health center. Worker doctors, like barefoot doctors, perform health work part time, while continuing their other duties.

The cities of China are divided into districts of several thousand people; the districts are divided into smaller neighborhoods and neighborhoods are divided into "residents' committees" and "residents' groups." Residents' committees usually have health stations which are staffed by "street doctors," another urban counterpart to the barefoot doctor.

Perhaps the clearest example of the work of the street doctors and their personal and intense involvement with their communities is their work in reducing China's birth rate. Birth control, like other facets of human behavior, is intimately tied to one's living conditions and one's level of political consciousness.

> Therefore, it is recognized that family planning is based upon the emancipation of the woman, her equality, her right to study and participate in all political decisions and her heightened social consciousness (Piotrow, 1971).

In the urban areas, street doctors are responsible for the dissemination of birth control information. They go from door to door, talking with the women about the number of children they want and the birth control methods they are using. By means of monthly visits to the home of each woman of childbearing age, street doctors keep careful

track of the types of contraceptives used. Most of these workers are housewives, often with two or three children: many have had tubal ligations themselves, so they serve as models for the women they visit. It is said that while no one is "forced" to limit the family to two or three children, great stress is put on educating people on the importance of population control--not necessarily for themselves, but rather for the neighborhood, the city and the nation (Orleans, 1972).

It appears that all the health workers who deal with women around the issue of birth control are women. Indeed, women have assumed a large role at all levels of China's medical care system. It is estimated that approximately 50 percent of the barefoot doctors and the overwhelming majority of street doctors and nurses are women. Some 30 to 40 percent of China's physicians are women, and the percentage is rising since, it is said, approximately 50 percent of medical students are females. Indeed, women seem to be attaining higher positions in medicine than in many other fields.

Urban personnel, including doctors and superspecialists, are assigned to the countryside, on a rotating basis. As many as one-third of the staff of an urban hospital may be away at any given time, spending from six months to a year in a rural area assigned to a specific location, such as a commune or a county hospital, for the purpose of bringing health care to the countryside and being themselves reeducated in all aspects of rural life.

As part of their attempt to equalize the quality of life in the cities and in the countryside, the Chinese are also building great

numbers of medical facilities in the rural areas. There is still, however, a relative shortage of medical resources in remote areas, even though the urban-rural distribution of medical resources can be considered a considerable success.

Payment Mechanism of Doctors

With the exception of the "barefoot doctors" who participate in the income and food production system of the communes, all medical personnel in the cities and the rural areas are now on salary--a change from the prevailing methods of some private practices into the early 1960s. Salary and status differences among medical personnel with different levels of expertise are apparently being reduced. Prior to the Cultural Revolution, following the Soviet pattern, great salary differentials had developed. Doctors who were particularly senior in specialization or in academic status often earned four to five times as much as a beginning doctor, and experienced doctors earned considerably more than experienced nurses or other health workers. One result of the Cultural Revolution has been a decision that wages at the upper end of the range will be frozen until wages at the lower end rise to meet them. This is a relatively new policy and its pattern of application, its consistency and its effects are not yet clear.

The income of "barefoot doctors" is generally determined in the same way as that of the other peasants in the commune; each peasant's earnings depend on the total income of the brigade and the number of "work points" that the individual collects. Barefoot doctors

receive work points for health work just as they would for agricultural work.

As far as "worker doctors" are concerned, they are paid a salary similar to that of the other workers in the factory.

> Salaries for hospital doctors range from 46 to 155 yuan per month; traditional and Western-trained doctors have the same salary scale. Nurses begin at 4 yuan per month; the highest paid nurse at the hospital in the fall of 1972 earned 69 yuan a month. Administrative personnel earn from 40 to 70 yuan a month (Sidel, 1973, p. 51).

It is very difficult to attempt to assess what is happening in China today as a result of the new Sino-American rapport. A change toward more emphasis on intellectual endeavor seems likely, as well as a shift toward values held prior to the Cultural Revolution. This would probably translate in a differentiation in pay as well as in status for doctors with more education and more experience.

Equitable Accessibility of Health Care

As far as the financing of medical care, methods vary widely both in the cities and in the rural areas. Workers in most industries have their medical care paid for by their factories; their families are subsidized for half the cost of the services and must pay the balances themselves.

Peasants in many communes may participate in a collective medical care system, each family paying into the fund an annual premium for each of its members. The entire family is then covered for all medical expenses except for payment of a nominal registration fee.

> The Chinese hope to see the elimination of all medical care payments when there are sufficient resources to make this possible. Apparently this, too, will be done on a decentralized basis. Meanwhile, the cost of individual services and of prepayment premiums are quite low, even when calculated as a percentage of a Chinese worker's income, and the payments are therefore felt to be little or no barrier to access to care. On the other hand, they do make it clear that the resources for medical care are not unlimited, and that responsibility should be exercised to use them appropriately. The time will come, the Chinese say, when people's socialist consciousness will be raised to the point where such reminders will no longer be necessary; that time, despite all the changes, has not yet come (Hu, 1976, p. 239).

The results of these changes in the medical system are readily apparent in China today. There is truly an availability of health care. It is available where the patient is and the necessary steps to more sophisticated care are functioning effectively.

Acupuncture and herbs, barefoot doctors and traditional doctors act as the first line to absorb the majority of problems. Regular doctors have been resettled in the commune hospitals and good second stage care, including obstetrics, general surgery, simple fractures, pediatrics and dentistry is handled there.

Roving health care teams bring on-the-job training to the rural areas; barefoot doctors and commune doctors have regular required periods in the backup city hospital.

Nevertheless, despite the vast changes that have taken place in the health of the Chinese people, problems of accessibility still remain to be solved. More than one decade after Mao's severe criticism of the health establishment for focusing on the urban rather than the rural areas, medical care remains considerably more accessible and of higher

technical quality in the cities than in the countryside. Buildings, equipment, resources of all kinds are more available in the urban areas. In addition, despite massive training efforts since 1949, a shortage of trained medical personnel still exists, and this shortage is almost surely more pronounced in the countryside than in the cities.

Furthermore, the changes that are taking place in China today because of the events of the past few months will probably result in a decrease in accessibility to health care, since it will no doubt increase the flow of medical personnel back to the cities, if the past is any indicator.

In summary, the health of the Chinese people has been transformed in just over one generation. This transformation, while due in large part to the basic changes in the society brought about by the Revolution, is also due to the transformation of the Chinese health and medical care system.

There are, of course, some major problems which remain to be solved. Barefoot doctors, who have provided a great deal of the medical care in the countryside, have also been criticized for occasionally attempting to perform more complex tasks than those for which they were trained. This is also a consequence of a continuing shortage of trained personnel both to perform complex medical procedures and to supervise lesser-trained workers.

Conversely, there are said to be patients who demand a more skilled health worker when one with lesser technical skills could adequately

perform the task. In other words, the problem of appropriately matching the health worker to the task has still to be fully solved in China, as in all countries.

In addition, the integration of traditional and Western medicine is by no means complete, and thus doctors of traditional medicine probably continue to have less status than "Western type" doctors.

Another issue which cannot be omitted from even a cursory study of the Republic of China is the question of whether their new "moral" man, who has accepted the rigor and demands of hard work, lack of individual freedom, puritanical behavior and bombardment of propaganda, can be maintained at this level of commitment. Initial excesses plus initial asceticism are characteristic of successful revolution. However, how much of the present Chinese model behavior can be maintained at such a level? Evidence that a change toward a more materialistic trend is already in the making is indicated by the new Sino-American relationship.

An entirely new approach to training a health care team has been launched by the Chinese. It is not a variant of the Russian or of any other system. It is Chinese, and if the Chinese are successful, one can only anticipate that many of the developing, so-called Third World countries will follow suit.

The American concept of prolonged special training has dominated much of the world. Many nations have either copied us or their young doctors have elected to come to us. The Doctor of Medicine degree, followed by several years of special training and final certification

has become the rule, not only in the United States, but in the Philippines, Taiwan, Hong Kong, Singapore, Indonesia, Burma, India, Turkey, Mexico, Colombia, Brazil--to name only a few countries. Many of these countries are poor and not all of their population has medical care. The painful end result of the American "professionalization" in many of these countries has been to produce intelligent, well-prepared specialists who cannot be afforded by their country and are useless to the majority of its population.

> The new Chinese policy has eliminated boards, certificates and barriers to movement up the health ladder. What they are doing may be a more exportable package to developing countries than our formal, nationwide, professional standards approach (Dimond, 1973, p. 167).

While the remaining problems of the Chinese medical system should not be minimized, they are small compared to the magnitude of the achievements of the past 25 years and small compared to the demonstrated successes of some of the radical departures from standard methods which the Chinese have introduced.

As far as what the future holds, it is extremely difficult for even the most astute "China watcher" to truly evaluate what will be happening in China: this gray area includes the health and medical systems as well. Therefore, it is impossible to draw conclusions based on the Chinese model, since recently it is in such a high state of flux.

Chapter 6

U.S. Medical Care System: The Free Enterprise, Laissez-faire Approach

Before turning to recommendations for the future of our own system, it seems well advised to briefly examine its historical background as well as the problems existing today in the health and medical care fields.

Medical care among the Puritans held few, if any, prospects of care as we know it, but was based rather on a special kind of preventive approach. It was widely felt that if a person adhered to the "Protestant Ethic"--leading a life compliant with fundamental law, replete with productive work for one's family and community--he would achieve health and satisfaction. There were, of course, many remedies for relief of pain and some other symptoms of illness, but many of the early Puritan colonists made few major attempts to interfere with what was seen as God's will (Weber, 1958).

By the time of the Great Awakening in the colonies, around 1740, the universe came to be seen as one in which "all men were created equal," in which there were natural rights, in which people could help one another through formal services including medical care.

The growth of the cities also forced the movement of charity, which had been largely a private matter, into the public sector. In 1736, New York City built an almshouse and the city council frequently appropriated funds to employ physicians to care for the destitute ill.

Folk medicine and self-care remained extremely important, especially in small, isolated settlements on the frontier, which could not support a doctor.

During the seventeenth and eighteenth centuries, most people healed or died at home--and were by all accounts much safer there than in the almshouse/hospitals where infectious diseases ran rampant. Despite their generally poor image during the second half of the eighteenth century, hospitals were established in some of the larger cities and began a tradition of training physicians, surgeons and, much later, nurses within the confines of the institution.

The current role of the hospital in therapeutic medicine did not fully develop, however, until the late nineteenth century, after the development of anesthesia, improved surgical techniques and the value of antisepsis and asepsis.

While the academic medical school and the hospital became the dominant sites for medical education and for specialized practice on the East Coast, further west the situation was different. During the westward expansion, opportunities for individuals to function in a variety of roles increased with the formation of new communities, and there was a growing demand for doctors to provide medical services. Much of this demand was met by lay practitioners, frequently women, who usually preferred herbs, diet and caring to the more dangerous and probably less efficient ministrations of many of the "regular" doctors. "Regular" doctors followed the instructions of Benjamin Rush, the most famous physician of the revolutionary period, who relied very heavily

on massive bloodletting and large doses of laxatives. By 1830, thirteen states passed medical licensing laws, outlawing "irregular" practice and establishing the "regulars" as the only legal healers.

The establishment of the American Medical Association in 1847 rekindled the flames. The battle against "quackery" continued in full force until the beginning of the twentieth century, when a combination of state medical societies and the AMA finally drove out much "irregular" practice and with it--until almost the present day--did away with much of the role of women in medicine in the United States.

With the advent of the Industrial Revolution in the mid-nineteenth century, the immigrants became prime candidates for the diseases of poverty. Devastating epidemics would affect the rich and the poor alike, and therefore aroused much concern. A large part of the drive for public health measures arose, not out of altruism or because the people afflicted were powerful enough to demand such measures, but because the people in power felt themselves endagered by the epidemics of communicable diseases. Thus, the public health movement began as a reaction of the powerful to the spread of disease, and the recognition that it could be controlled through sanitation. This trend of government involvement in health care, as a separate entity from medical care, has continued up to the present time through enforcement of sanitation laws, water supply regulations and control of communicable diseases.

By 1910, the AMA became concerned with the issue of financing national health insurance for the purpose of coordination and equitable distribution of medical services within society. In this and by

recommending a national health insurance, organized medicine in the days of pre-World War I was the advocate of liberal reform in the areas of health care and medical care in the country (Shyrock, 1962).

The profound changes in attitude which followed World War I--the shift in United States public opinion toward isolationism, protectionism and other forms of escapism--were reflected within organized medicine. In the early 1920s, the AMA was taken over by a group of private practitioners with a very different philosophy from that of their colleagues who had espoused national health insurance a decade before, and the organization began to function as a much more clearly defined "special interest" group.

The federal government did enter the field of medical care in a number of ways. The Social Security Act of 1935, along with its better known function of provision of income for the elderly, authorized grants to states for maternal and child health and welfare programs. In addition, workmen's compensation insurance for work-related injuries was federally mandated.

The opportunity for massive growth of federal involvement in medical care came with the election of the Johnson landslide Democratic Congress of 1964, which resulted in the enactment of two specific programs. One, Medicare, was an expansion of the social security system to provide coverage for everyone over the age of 65. The other, Medicaid, was a form of welfare for the "medically indigent" and was administered on a state basis with matching federal funds.

Over the past decade, not only has the United States health and medical care system not been mobilized to meet social needs, but it has in many ways been seriously weakened. In particular, the Nixon-Ford years saw a partial dismantling of public medical care in favor of private medical care and a reduction in federal funding for services for the poor and for minority groups.

In the 1960s, there had been some attempt to provide health services to those who most needed them. Programs for specific categorical health care needs had been developed, such as the federal government's newly established Office of Economic Opportunity, which funded neighborhood medical care demonstration projects in poor urban and rural areas. Health centers were started by the Children's Bureau of the Department of Health, Education and Welfare; additionally, the Regional Medical Program (R.M.P., Public Law 89-239) and the Comprehensive Health Planning Legislation (C.P.L., Public Law 89-749). Some funds for initial training of health workers had been made available. Under the Nixon administration, however, some of the best efforts of the past were cancelled in the name of economy, efficiency and local initiative (Gartner, 1973).

Over the last quarter century, United States society has been characterized by rapid changes: urbanization and suburbanization, which has left the inner city predominantly populated by the elderly, the economically deprived and by ethnic minorities. We should add to this a high degree of mobility of a great segment of the population, and the increasing number and proportion of older people in the population.

The change in proportion is due in part to the survival of more people in the older age group, but it is mainly due to a decreasing birth rate and, therefore, fewer numbers of younger people being added to the population.

Furthermore, while ours is among the most affluent of the world's societies, there are large numbers of people who do not share in its affluence. In 1976, 10 percent of all families in the United States--25 million people--had income below the "poverty" line. Inadequate housing and nutrition, inadequate education and job opportunities lead to an endless cycle of poverty and illness.

There has been a shift from a preponderance of acute infectious diseases as the leading cause of death to a preponderance of chronic, degenerative diseases which require community support far beyond that usually needed for infectious diseases. It is common knowledge that diseases such as smallpox, cholera, yellow fever, typus fever and polio--which ran rampant years ago--have almost completely disappeared in the United States. At the same time, the advent of sulfa drugs and then of penicillin have helped to deal in a very speedy and efficient way with many other infectious diseases, such as influenza and have been lifesaving and life sustaining for untold millions.

At the same time, there has been an increase in the proportion of older people in the population. Those aged 65 and over in the United States have increased from approximately six percent of the population thirty years ago to approximately ten percent of the population now. It is evident that this large segment of Americans are more prone to chronic illnesses, such as heart disease, arthritis and hyptertension.

If we add to this the drastic change in the structure of the family, with less accommodation and acceptance for older people, we are faced with an increased number of chronically ill elderly patients, who are putting an ever-increasing strain on community-based health facilities (Berry, 1973).

In conclusion, medical care in the United States has grown increasingly dysfunctional and somewhat incapable of meeting the changing needs brought about by changes in societal patterns and illness trends. We can now direct our attention to the four main areas of concern.

Hospitals

During the first half of the twentieth century, the hospital changed from a custodial institution to a complex workshop. Our hospitals have been proud, self-centered institutions. "Their growth and excellent depend mostly upon the breadth of vision of their trustees, the drive of their medical staff and the generosity of their private and governmental donors" (Rutstein, 1974, p. 7).

The word "hospital" generally conjures a picture of private, non-profit facilities established to provide short term care for rather acute illnesses. It is frequently forgotten that more than half of the 1.7 million hospital beds in this country are occupied by patients with chronic illnesses and disabilities. One-tenth of the beds are operated by the federal government for its special charges: military, veterans or public health hospitals.

Proprietary hospitals, operated for profit, are generally rare, but their number is increasing rapidly in a few metropolitan areas such as Los Angeles and suburban New York City. Most patients, however, receive short term care in voluntary (non-profit) hospitals containing 70 percent of the short term beds and admitting three-fourths of the patients for brief periods (Rushmer, 1975).

The board of trustees of the hospital is commonly composed of businessmen and community leaders with authority over both the hospital administration and the medical board, but with neither the background nor the technical knowledge to exercise its power. They are legally responsible for medical care, but in reality they have limited influence.

The ultimate responsibility for the quality of care is actually shared between the medical staff and the governing board of the hospital, acting on behalf of the community.

Since 1946, with the passage of the Hill-Burton Act, hospital construction has skyrocketed. "As of 1971, a total of 10,748 projects had been approved for the construction of health facilities, particularly hospitals and nursing homes" (Rushmer, 1975, p. 126).

By the late 1960s, some observers had come to realize that, however measured, the earlier bed shortage was clearly a part of history. In many communities, many of the beds in use were in obsolete buildings and sooner or later would have to be replaced, but the further expansion of short term hospital beds was no longer an issue. Indeed, a recent report by a committee of the Institute of Medicine concluded that the United States has too many hospital beds and that the early closure of

30,000 beds--about three percent of the total supply of short term beds --could be effected without any risk of reducing needed services and would offer other considerable cost savings, approximating one billion dollars annually (Institute of Medicine, 1976).

Interestingly, the distribution of hospital beds in the United States is much more equitable than that of physicians. In some ways, hospital bed distribution is used to make up for shortages of physicians. States, like South Dakota, which have low physician to population ratios, have relatively high hospital bed-population ratios.

There is indeed some maldistribution and misuse of hospital resources, but it takes a different form than that of physicians and other health workers. It occurs in the competition among hospitals, particularly in urban areas, for prestige enhancing equipment and for patients to keep the beds full.

As mentioned above, the leading hospitals compete for staff and patients with a variety of duplicated facilities including those for open heart surgery, cardiac catheterization, coronary care, intensive radiation therapy, isotope diagnostic labs, etc. Meanwhile, several groups of patients have little access to any health care providers, primarily the rural poor and the inner city disadvantaged, many of whom are racial minorities with low income.

Expanded numbers of health care personnel, coupled with recent trends toward rising wages, are key elements in the soaring costs of hospitalization. This is compounded by the fact that substantial numbers of beds lie empty.

> On the average day last year about 318,000 hospital beds, one out of five, were empty across the United States. Obviously some hospitals are full and have waiting lists, but there are several thousand empty hospital beds in New York City alone, and six cities are reported to have 4,000 beds more than they need. The costs of hospitalization are greatly increased when the occupancy rates diminish (Rushmer, 1975, p. 29).

Site of Practice of Doctors

Contrary to popular belief, the shortage of physicians in this country results more from excessive specialization and maldistribution than from insufficient numbers of health professionals. The number of family physicians is inadequate for current needs, while certain categories of specialists have been trained in excess of actual requirements.

These surplus physicians concentrate in metropolitan and suburban areas, while remote and rural areas suffer deficiencies of health care, many of which cannot be realistically offset merely by dispersing physicians into these areas.

Physicians living in wealthy suburban areas near large cities find life extremely pleasant, professional contacts and facilities convenient and patients relatively healthy, well nourished and able to pay. For these reasons, physicians tend to congregate in and near large urban centers in numbers amounting to a major surplus.

> For example, New York City contains about four percent of the population of the United States, but nine percent of the physicians are located there. Imagine, nearly one doctor in every ten in this country lives in a very small area in and around Manhattan Island, yet its ghettos contain thousands of people lacking even minimal care (Rushmer, 1975, p. 24).

The reason the number of physicians is totally inadequate in both the centers of major cities and the more rural areas is simple: the

depression of living conditions and of incomes in these areas are powerful incentives to physicians.

Incentives that might encourage physicians to settle in such locations have proved largely ineffectual. After a prolonged standoff because of differences between key committees in the House and the Senate on the principles of effecting physician redistribution, a new health manpower act was passed in October, 1976 (PL 94-484). The act makes future federal aid to medical schools dependent upon student commitments to practice in underserved areas upon the completion of their training. The results of this act have yet to be felt in any measurable degree.

Our current alternative would be to train paraprofessionals to help relieve the heavy loads of rural and inner city physicians. Some smaller towns contain adequate medical care, but in many parts of the Midwest and of the Southwest and in the Rocky Mountain area, thousands of counties have no physician at all (Rushmer, 1975). Many of the more prosperous communities in these areas have unsuccessfully attempted to attract physicians by building hospitals or clinics and by guaranteeing income.

There are various reasons for the failure of such incentives. Rural physicians are often solely responsible for large population spread over vast areas, so they tend to be overburdened and under unremitting pressure. Their remuneration is small compared with that of their urban colleagues, and they must function without the convenience and the support of modern hospitals and sophisticated health facilities and

services. They deal with a very large number of routine, mundane, and even trivial problems that are neither intellectually stimulating nor professionally satisfying. Isolated from medical centers, they quickly fall behind the rapid surges of scientific progress. They have difficulty finding substitutes to allow for vacations or for periods of study and rarely have time to enjoy the financial fruits of their efforts. Since freedom of location is, but for few exceptions, the case in the United States, it is no wonder that free choice commonly favors suburban practice.

A variety of experiments are being explored in an attempt to encourage health professionals to choose rural or remote areas after graduation. In the Medex program, for example, physicians' assistants are chosen from among highly experienced medical corpsmen after their discharge from the military. After intense work in medical centers, they complete their training by working with rural physicians who have agreed to employ them. These men have demonstrated an ability to assume a great deal of responsibility and have received acceptance from both physicians and patients (Smith, 1970).

It appears evident that there is no prospect of providing health care personnel and facilities in the quantity and quality required to cover all the needs of residents of rural areas and of inner cities. Even the alternative of training paraprofessionals is not going to be sufficient. The only solution will probably lie in utilizing more effectively our sophisticated communication network and transportation capabilities to transmit information from patients to medical centers

and to convey patients to the appropriate facilities for the treatment of their illnesses.

Payment Mechanism of Doctors

In the United States, the physician is compensated through a fee-for-service system in which he bills the patient, the insurance company or the government for each individual service provided to the patient.

In 1950, the per capita expenditure for physician's services was less than $18 a year; in 1975, this figure had risen to over $105, or sixfold. In the beginning of the period, 85 percent of all spending for physicians' services was in the form of direct payment from patients; by 1975, the share of direct payments had declined to just under 40 percent (Gibson, 1976). Two developments were responsible for this shift. The first was the accelerated growth of private insurance. The second was a parallel increase in payments to physicians from public funds--from 5 percent to 25 percent during the period (Gibson, 1976). Insurance and government, which together had accounted for only about one-sixth of all payments at the beginning of the period, were responsible for three-fifths at its end.

The growth of health insurance introduced a new factor in the purchase of physicians' services. Since many consumers no longer pay their physicians directly, they are less likely to economize in the use of physicians' services. At the same time, the services that a patient obtains from his physician have not remained the same over the past three decades, since they involve more complex equipment, more

tests and more staff assistants, which contribute to rising physician costs.

The availability and quality of medical care are affected by the way physicians are paid in our health care system. While a significant proportion of their work is performed in hospitals, most physicians are not paid by these health institutions, but by their patients, on a fee for service basis.

> Physicians earn more if they perform more fee generating services and they typically work long hours: non-federal physicians in office practice worked an average of 49.9 hours per week in 1974 (Bishop, 1977, p. 208)

That physician incomes are high is to be expected for workers who make such a large time and money investment in their training. "The average net income for non-federal physicians in office based practice was $51,224 in 1974" (Bishop, 1977, p. 208).

High incomes mean that subsidies to induce physicians to practice in areas or specialities where they are most needed are unlikely to be effective, since physicians can apparently do well in most of the locations or specialities they might choose.

Plans to improve the availability and quality of health care in this country and to control its total cost may involve changes in the way in which physicians are paid. Under a prepaid group practice arrangement, for example, individuals pay the group practice organization a premium or capitation, which covers all health care for a year. If physicians choose less costly modes of care and avoid tests and procedures that have only marginal value for patient health, savings can then be

returned to the organization for distribution to physician members. It has been argued that physicians will not work as long hours for salaries or group rewards as they do for individual fees. However, this should not be cause for great concern in light of our expanding physician supply.

Whatever the basis for the payment of physicians might be in our future national health service, one thing should always be considered: the practice of medicine places severe demands on the physicians. As long as the period of education and training needed to become a doctor continues to be so long and involves such an expensive investment on the part of the doctor to be, physicians' incomes can be expected to be high. If we add to this factor the unusual demands that the practice of medicine place on the conscientious physician, we can easily predict a continued expectation on their part for generous financial rewards.

Equitable Accessibility of Health Care

As a result of the agricultural revolution, a mass migration from farms and small towns to the cities has congested our metropolitan areas, leaving large areas of the contiguous states and Alaska sparsely populated. People who live in rural areas of this country almost always suffer from insuffucient access to good health care. Many counties are without a single physician, so that they must depend upon distant towns for their health care.

Inadequate access to health care is a sorry enough condition for those rural people who can afford to pay; the plight of poor farmers

and of migrant workers is indeed tragic, since their geographic isolation compounds their socioeconomic disadvantages.

> Both members of Congress and state legislators are under constant pressure from rural constituencies that fear they will have no doctor when their elderly general practitioner retires. Other communities have been without a physician for years, unsuccessful in their efforts to recruit one, despite their offer to provide well equipped facilities, supporting help and an assured income (Ginzberg, 1977, p. 69).

But although access to health care in many rural areas remain a problem for which no ready solution is at hand, the crux of the access lies in the inner cities, which house large numbers of low income families, many of whom have only recently settled there and have not yet adjusted; others who do not speak English, and some of whom may be in the country illegally.

Paradoxically, the inner city is also the location of some of the nation's foremost teaching hospitals, with their sizable staffs of physicians and allied health manpower. But the inner city lacks private practitioners, many of whom have relocated to the suburbs. The small number of private practitioners located in low income areas implies that ghetto residents will find it difficult and often impossible to be treated by a physician of their own choosing. Another measure of inadequate access is the long waiting times associated with treatment in emergency rooms and outpatient clinics of nearby hospitals which provide inner city residents with the only source of medical care. These facilities are often clogged to the point that real emergencies are neglected.

> The allocation of additional money for Medicare and Medicaid will not solve this complex problem, because these programs do not focus on the root issues. We have failed to develop the incentives necessary to distribute the surplus resources of health care personnel and facilities more equitably among people so close geographically and yet so distant in terms of their environmental conditions (Rushmer, 1975, p. 89).

By any standard, the native Americans form the group who suffer the most from the unavailability of health resources, despite the efforts of the Indian Health Service, which is responsible to some 400,000 American Indians and Alaskan natives.

The infant mortality rate of native Americans is more than three times that of whites. The crude death rate of Alaskan natives is more than twice that of white Alaskans. Respiratory infections are extremely common, and in children they frequently produce severe bronchitis which is very rare among children in other parts of the country. The director of the Alaskan Native Medical Center has suggested that the high rate of mental retardation is largely due to the residual damage of acute infectious diseases early in life (Euglender, 1970).

Current debate in the United States over inadequate access centers not only on geographic problems, but more and more on financial factors which preclude some families from receiving the same attention and care as others. The costs of health services have reached such high levels that they are beyond the reach of a large segment of the population, particularly those not covered by insurance or other third party payments. True, the passage of Medicare and Medicaid has helped breach the gap in the rate of utilization of health services among poor and non-poor. However, since financial barriers to health care are still very

pronounced, the poor will resort to home remedies, limit physician contacts and skimp on follow-up care.

Other aspects of the issue of access are worth noting. Despite Medicare, there are special problems that senior citizens face in obtaining health services. Many older persons who are shut-ins cannot find a physician who is willing to care for them in their homes. Others who are in nursing homes often lack adequate medical or nursing care.

In summary, health care delivery unexcelled anywhere in the world is readily available to people fortunate enough to live in the more affluent sections of metropolitan and suburban areas in this country. For the people who inhabit remote areas, for some minorities and for the poor, problems of accessibility to health and medical care still exist.

Chapter 7

Conclusion: Proposals and Recommendations For Change

It is the author's opinion, based on readings and observations, that the medical and health care of the four countries examined could best be compared to that of the United States, by the visual aid of the following figure.

Each point of comparison has been put on a scale of 1 to 5, with five being the highest rating. This is a completely subjective analysis of the variables examined in each of the countries, and the information was integrated into this figure.

Hospitals

The following points have been laid open for examination, analysis and conclusion: total number of hospitals in a given country, including general and specialty hospitals; number of beds available per capita, including private, semi-private and wards; technical equipment, including operating room, delivery room, pharmacy, laboratory and x-ray department; outpatient and emergency departments, and location of hospitals. The rating is based primarily upon these quantitative factors,and it is not a qualitative decision at all. Five will indicate a highest ratio per capita, and one the smallest.

Site of Practice of Doctors

The factors taken into consideration had either negative or positive aspects in relation to the best conditions under which physicians can

practice medicine. The negative factors were: physicians working exclusively out of a hospital and physicians working exclusively out of their own office. The positive factors were: a combination of working from their office and the hospital, partnership and group practice, freedom of practice location and ratio of physicians to population.

Payment Mechanism of Doctors

The items investigated and explored were: full time salaried physicians, including those receiving all of their remuneration through governmental bodies; physicians paid on a fee-for-service basis; physicians receiving remuneration under a prepaid and/or group practice plan; the capitation system; and various insurance coverages.

Equitable Accessibility of Health Care

A research was made of the following factors: accessibility, both from a financial and from a geographical point of view, in rural and urban areas; use of paramedic workers; the plight of shut-ins, elderly and various ethnic groups; and the queue problem.

Table 1

Points of Comparison

Countries	Hospitals	Site of Practice of Doctors	Payment Mechanism of Doctors	Equitable Accessibility of Health Care
Sweden	4	4	4	4
Great Britain	3	3	5	3
USSR	2	2	3	2
China	1	1	1	5
United States	5	5	2	1

While we cannot obviously expect to transplant techniques and systems from one society to another, a number of fundamental principles have emerged. Sweden's attempts at regionalization and its efforts in preventive medicine; Great Britain's commitment to equity in provision of care and to the maintenance of community based primary care; the Soviet Union's guarantee of basic medical care to its entire population without charge at the time of service; and China's extensive use of paraprofessional health workers to provide health and medicare care where it is needed the most--all are examples of ways in which health and medical care can further goals of equity and accessibilty.

Each country may be said to have evolved the kind of health service it deserves--no better nor worse than the environing situations allowed. Yet it would appear that in no country there is general satisfaction with the status quo. The belief in progress runs strong, and the very dynamics of medical technology make it impossible to stand still. Each country has evolved a financing and organizational pattern that appears to be congruent with its social and political system. No country seems to feel it has solved the cost problem, but they vary in the extent to which they have solved the access problem of the poor. No country has solved the problem of distributing physicians to areas where they may not like to practice, although the People's Republic of China has done better at this than the other countries.

The United States stands at the threshold of long range shifts in methods of delivering and financing services, as revealed by the many legislative proposals now being put forth.

A group of proposals, sponsored respectively by the AMA and by the insurance companies, would leave the current practice of medicine unmodified and leave unchanged the role of the insurance companies. Their main flaw is that they are based on imposing significant deductible and coinsurance payments on patients and families at the time of illness in the name of "keeping down costs." These financial barriers would diminish equity in distribution and therefore weaken the effectiveness of the plan. At present, there are three major proposals for health reform on the Congressional agenda, each of which covers only a small part of the population and is intended as a "first phase" in implementing health care on a more comprehensive level.

The first proposal, known as the catastrophic illness insurance, provides different alternatives for the protection of excessive medical expenditures. A recent analysis by the Congressional Budget Office (January, 1977) reveals that a significant number of persons incur large expenditures for health services, measured either in terms of costs of over $5,000 or 15 percent or more of their income.

The long-term care issue has also been analyzed by the Congressional Budget Office (February, 1977). It includes both health and social services required by the elderly and the disabled. These services can be provided in a nursing home, in their own home or in an intermediary facility. The level of expenditure is difficult to determine, because there is no reliable basis for estimating the universe of need or the level of need.

The third proposal which is attracting considerable attention is the National Health Insurance for Mothers and Children Act (95th

Congress, S.370), known as the Kiddicare Bill, which was reintroduced in the Senate and the House early in 1977 by Senator Javits and Representative Scheuer. The major thrust of the bill is to cover the cost of all the health needs of children up to the age of eighteen and of all women during pregnancy and for twelve weeks thereafter. This proposal has long been a favorite of those who believe that the path to national health insurance requires staging, and that the goal cannot be achieved in one giant step forward.

There is only one plan that has the widespread support of organized labor as well as of the "liberal" establishment in medicine: it is the Kennedy-Corman bill and would provide universal eligibility and care, free at the point of service. This bill would eliminate the role of insurance companies, would eliminate deductible and coinsurance payments, would encourage more equitable distribution of large segments of medicine, would encourage group practice and would use a largely "progressive" system of taxation as its source of funds.

What we have in the United States today as far as the health and medical system is concerned is closer in many ways to the futuristic vision of some of the proponents of health reform than those who have vested interests in keeping it from changing would have us believe. Those who oppose any changes in the status quo often quote five basic myths:

1. _Medicine is a "small business," self-employed, totally entrepreneurial profession._ In reality, one-fourth or more doctors in the United States already work on a salaried basis.

2. <u>Medical care is purchased by individuals from the physician of their choice</u>. In reality, 40 percent of the funding for health and medical care comes from tax funds, and an additional 30 percent comes from pooled insurance funds. Furthermore, large groups are already served by a public medical care system, such as the Armed Forces, the Veterans Administration, the United States Public Health Service, etc. The President of the United States, our Cabinet members, Congressmen and other government officials are also the recipients of national health care, and in many cases find nothing inconsistent about railing against this form of medical care and accepting it at the same time.

3. <u>Doctors are free to practice wherever they wish</u>. In reality, doctors whose education is paid by government agencies such as the Armed Forces or the National Health Service Corps give up a considerable degree of freedom about where and how they practice for at least a portion of their careers.

4. <u>Doctors pay for their own medical education and should be free, therefore, to practice medicine in ways that will maximize income, to "make up for past expenses</u>." In reality, today over half of the costs of medical education are already borne by government at one level or another and for some students almost all expenses are already covered by one government agency or another.

5. <u>Prior to the passage of Medicare and Medicaid in 1965, many analysts believed that our health care system would be swamped by persons who previously had not sought treatment, because of lack of financial means</u>. In reality, these fears proved exaggerated. For the

most part, physicians, clinics, hospitals and nursing homes were able to handle the increased demand for services with very little problem.

Who are the advocates of medical and health care reforms in the political arena today? A look at the people and at the forces behind the major proposals for health reform on the nation's agenda reveals the answer: a loose association of concerned consumers, of labor union leaders (whose members indirectly and sometimes directly must cover steeply rising insurance premiums), some political leaders who see health reform as a winning issue, and many health analysts in academic and governmental positions who believe that the present system is both inefficient and inequitable and could be substantially improved.

It is very difficult to estimate when these voices of change will be effectively heard. Ours is a system of challenge and response. Congressmen are likely to enact radically new proposals only when there are clear and unmistakable signals from their constituents that inaction is the greater risk. For example, only when Congress became unable to deal with the monopolies in 1890 did it pass the Sherman Anti-Trust Act; the collapse of the market system in the Great Depression of 1930-33 paved the way for the New Deal legislation of 1933-35. When the cost of insurance premiums becomes so high that American middle class consumers find themselves unable or unwilling to meet them, then--but probably only then--will the stage be set for major health reforms. At that point, most of the presently silent and unengaged public, who now prefer to leave matters alone, could be recruited to the side of the reformers.

It appears evident from the author's readings and observations that the present United States health care and medical care system, from almost every point of view, is only partially meeting its responsibilities in the promotion of health and in the provision of humane and efficient care.

> Health expenditures continue to increase at a faster rate than the economy as a whole. In the fiscal year 1977, for example, health spending rose twelve percent while GNP increased by 10 percent. Health as a proportion of the GNP has grown from 7.2 percent in 1970 to 8.8 percent in 1977. The exceptionally rapid rate of increase in health care prices is the major cause of the faster growth in outlays for health. Price increases for medical care services have been outpacing the other major necessities of life (except for fuel in 1977) (Social Security, 1978).

Since government--federal, state and local--is now the source of more than 42 percent of every dollar expended for health care, the control and the reform of the health care industry is and will certainly remain in the political arena.

Today, the average American is spending in unprecedented proportions.

> The total health spending figure of $162.6 billion translates into $737 for each person in the country. The average person spent $297 for hospital care, $146 for physician's services and $57 for drugs and drug sundries. An additional $90 was spent per person for items other than personal health care--research, health related construction, public health, and the prepayment cost of private health insurance (Social Security, 1978).

There is no reason to believe that this upward spiral is going to diminish: this will result in increased lack of accessibility to more and more people.

For the sake of equity and to test the caring qualities of our society, a systematic attempt should be made to get comprehensive services to the poor by two chief methods. One is a generous government subsidy to buy health insurance policies from the current insurance agencies to facilitate entry to the mainstream of American medicine on the part of the poor or non-working. Parallel to this, massive incentive subsidies to hospitals and medical centers to provide service in underserved areas would be in order.

For the employed segment of the population--an overwhelming proportion of whom already carry some type of health insurance in connection with their employment--there should be a federal health insurance system to cover high cost episodes of given magnitude, say above $15,000. Therefore, at a relatively modest cost, the poor and non-working would get comprehensive services for nothing and with options, while the employed and earning segment of the population would be rid of the fear of financial catastrophe.

> We have to have federal leadership to do that. We need the federal taxing structure to raise the money, to set the standards and to redistribute the resources. But local control remains imperative. Reality tells us that, regardless of our rhetoric, we cannot produce more access to better health care at less cost. It is also apparent that the present distribution of available health care has little relevance to need and this misalignment is not improving (Pickett, 1978, p. 68).

Any future change in the structure of the current health and medical care system is going to be a political one and modifications will likely evolve from election to election. Our tripartite division of powers--legislative, administrative, judicial--complicated by a federation of states, sets the stage for a freewheeling method of policy formation.

The parliamentary systems of Great Britain and Sweden, the dictatorships of Soviet Russia and China, make for tidier policy development.

The trend toward increasingly official planning bodies such as the Health Systems Agency will likely lead to a tight system not desired in the American context. Some planning will still be needed on a voluntary basis, in order to avoid duplication and excessive use of service. No central planning body has the ability to determine adequacy of facilities and personnel.

A general system approach is being used more and more in the health field today. This gathering interest should replace the previously native notion that the health services can be manipulated piecemeal, without affecting the other components of the system. The health services can be conceptualized as a system, with points of entry and exits for the patient. There are identifiable types of facilities and organizational structures. There are identifiable types of personnel, medical programs, health insurance mechanisms and training centers.

There is a contribution to be made, by ranging from careful interpreting where data are available to plausible inferences where they are not. Data are available, for example, for patterns of use of health services, facilities and personnel, providing a basis to draw on in describing the health services. However, when dealing with political and social philosophies and how they affect health services, the emphasis must be on plausible and reasonable inferences based on reading and experience. Inferences here are on slippery ground, because there may be other interpretations that are equally plausible and

reasonable. As expressed by Barrington Moore, "All that the social historian can do is point to a contingent connection among changes in the structure of society" (Moore, 1966, p. 29).

This approach is justified, because of the open nature of the subject. The health services structure is ready for a detailed and rigorous system approach, to permit the testing of precise hypotheses.

The preceding recommendations flow from an assessment of what the author feels is politically feasible, financially acceptable, and reasonably equitable in the context of the American political and social system.

If this country will fund a generously proportioned system of options for the middle and high income patients and comprehensive services for the low income patients, it can be both dynamic and equitable.

It was not the author's intention to present a clear-cut solution to the present American care dilemma. A further in-depth study would be necessary if one would attempt to implement a workable system. Suggested research in this area would include a look at other medical and health care systems, such as Canada, West Germany, Australia, etc. In addition, comprehensive research into the past few years of the Congressional Records would undoubtedly reveal many bills with partial built-in solutions, such as bills pertaining to a National Health Service and a national health insurance system.

It is my hope that this paper will awaken in some measure the interest of the reader to pursue the study of this vital aspect of

American life. But I must accompany this with a warning. No system can be perfect which is made of fallible humans, and we are all fallible. The framers of our Constitution two centuries ago were well aware of it. There must be a set of checks and balances to our health care system of the future. Even to create it, the power to do so must be seized back by the people and soon. If it is not--in the nation as in the health care system--some of the reforms which may look good today could be the building blocks of larger and larger bureaucracies which will become more and more entrenched and less and less open to change. There is, as yet, no method of intelligent and deliberate change to which all interested groups will agree.

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