Pediat. Res. *3:* 475–480 (1969)

Acceptance of the Howland Award

by

ALLAN M. BUTLER[43],

Professcr Pediatrics Emeritus and Honorary Physician, Harvard Medical School,
Massachusetts General Hospital Boston, Massachusetts, USA

Thank you President Diamond and Dr. Talbot, not only for your part in this John Howland Award, but also for our friendship of nearly 40 years. Having known the previous recipients, I am grateful to the American Pediatric Society for being designated a recipient of this award and appreciate the honor of becoming a member of this elite group.

Dr. Cook has told me a written acceptance speech is compulsory—as compulsory as Universal National Health Insurance, that is, it is required. In it, I wish to acknowledge my indebtedness to others; brief mention should be made of my Dr. Jekyll and Mr. Hyde roles in medical science and social medicine, and I want to discuss the evolution of Universal National Health Insurance and what must be done to make it work.

My Indebtedness

Since what we are and do depends so much on others, I wish to record my good fortune in having had the privilege of working under Alfred Redfield and James Gamble as one of the first two tutorial students of the Harvard Medical School; Donald Van Slyke and Laurence Henderson, who taught me what I know of physiologic chemistry; Kenneth Blackfan, who set an example of patient consideration, lack of pretense and clinical wisdom; and James Gamble again, during the 20 years of working with him on water and electrolyte metabolism. During the period 1928–1941, with a research budget that averaged $ 2300 per year, there was the satisfaction of devising a method for determining sodium in biological material [27] that was used in describing the greater loss of potassium than sodium in diarrhea [23] and therapeutically induced diuresis [33]. This method was also used by Robert Loeb in detecting the sodium deficiency of Addison's disease. There was the satisfaction of separating the serum proteins [18, 24], describing the first, I think, clinical micromethod of determining para-aminobenzene sulphonamide in blood [37], and measuring ascorbic acid in white cells [8, 20–22, 33, 38]; the last is especially mentioned because its inadequate application to appraising the effects of infection and stress on ascorbic acid requirement has been a disappointment. Then, there were elucidations of clinical syndromes [1, 2, 6, 7, 25, 26, 28, 31, 36, 39, 40].

And what good fortune in having Nathan Talbot show me the wisdom of the body in handling parenteral fluids [41] and in having been taught so much by Fuller Albright, John Crawford, Lytt Gardner, Fred Blodgett, John Radebough, Charles Lowe, and the too many to enumerate associates with whom I am recorded as co-author of papers published during the past 38 years. How interesting and enjoyable were the years of 1962–1964 studying California's County Hospitals with Leslie Corsa [19] and its Maternal and Child Health Conferences with Bell Poole.

Thanks to one and all.

The Financing and Delivery of Health Services

And now to a field of medicine in which I've been laboring since retirement from Harvard and the Massachusetts General Hospital in 1960 [4, 9–17, 32] and in which I've been interested since the Report of the

Committee on the cost of Medical Care in 1932 and the two-volume documentation of American Medicine, Expert Testimony out of Court, 1937 [5]. Here, I owe so much to John P. Peters of the Committee of Physicians For The Improvement of Medical Care 1937 [30]; to Hugh Cabot, Robert De Normandy, Channing Frothingham and Edward Young, as partners in Medical and Surgical Associates in the establishment in 1939 of the White Cross Health Service, Inc. prepayment plan [3, 30], which, with the collaboration of 148 practicing physicians [42], provided comprehensive medical care to 20,000 people of Greater Boston; and last, but not least, to Ernest Boas of the Physicians Forum, 1941. How informative was participation from 1960–61 in the development of the salaried staff of the Metropolitan Hospital of Detroit to provide prepaid comprehensive health care to the 75,000 members of the Community Health Association.

It should be noted that this interest has two components: 1) the financing of medical care by insurance or prepayment; and 2) the quality and efficient delivery of medical services. Health insurance has the potentiality of improving the financing of health services by removing the uncertainties and burdens that pertain to individuals financing professional or hospital services as they occur by item fees or charges. Unfortunately, what I said thirty years ago (before Medicaid), in discussing the quality of care under a national health act, needs to be said again:

'The Wagner Bill places relatively too much emphasis on making federal money available to states and too little emphasis on safeguarding high standards and economical service. Available experience shows that current individual practice and tax supported medicine are incompatible. It is one thing to have a patient pay a doctor for each visit or service rendered and a far different thing to have a third party make the payment. When the patient pays, there is an automatic check on unnecessary and extravagant medicine. When a third party pays, there is the opportunity of malingering on the part of patients and of prolonging or exaggerating treatment on the part of physicians. The incompatibility of individualistic fee-for-service practice and tax supported medicine has long been recognized by the American Medical Association. Its desire to defend the former explains its past opposition to the latter. [15].

The differentiation and interrelations of financing and delivering services were appreciated over thirty years ago by both the Committee on the Cost of Medical Care and the Committee of Physicians for the Improvement of Medical Care [29]. The former, in recommending prepayment, advocated provision of services by hospital centered group practices developed according to regional planning. The latter presented four principles and nine proposals to the Medical profession for consideration. The principles state: 1. that the health of the people is a direct concern of the government; 2. that a national public health policy directed toward all groups of the population should be formulated; 3. that the problem of economic need and the problem of providing adequate medical care are not identical and may require different approaches for solution; and 4. that in the provision of adequate medical care for the population, four agencies are concerned—voluntary agencies and local, state and federal governments. The proposals advocated: minimizing the risk of illness by prevention; providing adequate medical care for the medically indigent, meeting the cost from public funds—local and/or State and/or federal; support of medical education, research and procedures for raising the standards of medical practice from public funds; the allocation of public funds to existing private institutions to the largest possible extent so long as their service is in consonance with the above principles; and a functional consolidation of all federal health and medical activities under a separate department. The subscribers to the above principles and proposals held the view that health insurance alone does not offer a satisfactory solution to the problems of improving medical care.

An editorial in the New England Journal of Medicine [29] gives the statement of the Committee's Principles and Proposals in full, together with the names of the original committee members, a partial list of the signers and the reaction of the American Medical Association. It states in part:

'This issue of the Journal presents to its readers certain principles and proposals which some four hundred physicians believe should guide efforts to improve medical care. The impressive cross section of the profession represented in the list of signers (ultimately over 1000) indicates that these principles and proposals deserve earnest consideration...

'Regardless of what the final solution to the problem raised may be, there seems little in the proposals or attitudes of the signers (of which I am one) to provoke such caustic comment as was made in the Journal of the American Medical Association... The frequency with which pertinent discussion of these problems by physicians has been diverted by befogging the immediate issue with emotions stirred by some irrelevant traditional loyalty has verged on insult to the intelligence of the medical profession...

'The Journal of the American Medical Association could render a much needed service by an enlightened discussion of the ways and means of meeting the problems that face the medical profession because of present

social trends. Many members of the American Medical Association are rightfully interested in an impartial presentation of these complicated questions, questions so complicated that their constructive consideration may all too easily be jeopardized by emotions arising from irrational prejudice...

'The New York Times comments editorially:

"Physicians of the highest standing have circulated a letter in which they call upon their profession to assent to certain general propositions, one of which is the propriety of supplementing inadequate private endowments by grants from public funds—local, state, and possibly federal—to medical schools, hospitals and research laboratories.

"Outraged at this seeming violation of organized medicine's economic interest in the treatment of disease and in research, the Journal of the American Medical Association regards the general proposition as a step in the direction of socialized medicine."'

The New England Journal of Medicine editorial continues:

'The editorial writer of the Journal of the American Medical Association apparently favors no such participation by any government, and this difference of opinion provokes disrespect. He states:

"The tender of governmental funds to such institutions for the care of an ill-defined group called the medically indigent appeals to the unthinking physicians who have endorsed these principles... Yet such an arrangement would put the hospitals promptly into the practice of medicine...

"Obviously some of these physicians must have signed merely after seeing the names of those who signed previously and because it looked like a good list... Most conspicuous on the list are the names of those deans and heads of departments in medical schools who may have signed because they saw a possibility of getting government money for clinics and dispensaries. Such careless participation in propaganda as has occurred is lamentable, to say the least. Certainly the unthinking endorsers of the... principles and proposals owe to the medical profession some prompt disclaimers."'

This New England Journal of Medicine editorial, quoted in part here, which I confess writing, was published November 11, Armistice Day 1937 [29].

In the February 3, 1969 issue of the AMA News, we learn that the American Medical Association recognizes 'that there are not only those in the population who can't contribute any part of the cost (that is, of health insurance), but there is another large segment of the population that is probably going to need help in purchasing insurance and, therefore, we have enunciated this new policy, which says that a fair degree of comprehensive coverage should be provided every American; that the federal government properly should assist to the degree needed in helping the individual to purchase this; that this should be a strictly federal responsibility rather than a matching federal-state responsibility; and that the best measure of ability to pay is through the income tax system, because it allows for more than just gross income. It allows for the deductions for dependents and for all the other things that go into reducing gross income and converting this to disposable income.'

We've come a long way, Baby.

With the American Medical Association, the National Medical Association, the Physicians Forum, the American Public Health Association, the Medical Committee for Human Rights, the Student Health Organization, the C.I.O.-A.F.L., the Committee for National Health Insurance, the National Health Forum, and others advocating universal National health insurance, National Health Insurance is on its way. *But* with its coming, it is essential that we give thoughtful consideration and take constructive action to improve the delivery of health services. We must improve their availability, economy, and quality by a more efficient application of our knowledge and resources [4, 10, 15, 17].

I think we all know the major defects of our disorganized health care that have lead to what is generally recognized as the present critical state of U.S. Medicine, namely, lack of planning and coordination of health facilities, disorganized delivery of services, fragmented financing with high overhead of our multiplicity of private insurance and government programs and agencies; built-in dual standards of private and welfare medicine; costly Medicaid and welfare means tests; fee-for-service remuneration of physicians and hospitals; solo-practice; and limitation of most health insurance to in-hospital care with resulting costly overhospitalization.

The Blue Shield in its publication Sources and the Committee for National Health Insurance in its pamphlet have documented the inadequacy of private health insurance. Approximately 16 % of people under 65 have no hospital insurance; 22 % have no surgical insurance; 49 % have no insurance to cover x-ray and laboratory examinations when not in a hospital; 60 % have no insurance for visits to doctors' offices or doctors' visits to their homes; 64 % have no insurance against the cost of prescribed drugs; and 97 % have no insurance against dental expenses.

Our private health insurance is not only grossly inadequate but, as stated by Dr. Lorin Kerr [34], it has reinforced the status quo and thereby obstructed resolution of the problems concerned with quality controls, use of manpower, and the organization and distribution of medical care services.'

A major cause of the failure of voluntary private health insurance is the fixed premium for a given policy. This has to be low enough to have a reasonable proportion of the people subscribe, and yet is too high for many millions to afford. It results in too little money to finance a single high quality of service for all and hence results in 'welfare' medicine with degrading and administratively expensive means tests at the time care is needed.

Dr. Kerr and the Committee for National Health Insurance state that the United States is the only industrialized nation in the world without comprehensive health insurance. I think the latest figures indicate that 17 of such nations have lower infant mortality rates than we have; at least 17 have longer life expectancy for males, and 10 have longer expectancy for females. More males are dying at middle age in the U.S. than in 15 of these nations.

The lack of economy in our disorganized system of delivering health services is indicated by our per capita expenditure of approximately $ 250 for personal health care in 1968, probably more than any country in the world. This amounts to 53 billion dollars, or 6.5 % of our 1968 gross national product. Yet the health care of the majority of our population is mediocre.

Experience with Medicaid shows clearly that universal health insurance could be disastrous in terms of economy and quality of medical care and return on the dollars spent, unless certain provisions are made to improve the financing and delivery of health services.

To accomplish an adequate and economical financing of medical care we at least should:

1. Finance Universal National Health Insurance by our tradition of charging for medical services according to ability to pay. The needed sums from general revenue could be economically provided by a surtax on the income tax, as we have done to finance the Vietnam war. At hand without added expense are the personnel and computers that levy a progressive tax based on fairly reliable data on ability to pay, in spite of the exemptions that can be managed by the very rich. And if Social Security is to finance some of the cost, why shouldn't prepayment of Social Security from wages be progressive like our income tax and not be based on taxing wages up to only a specific limit, such as the present $ 7800 per year. Local school taxes are based on all property, not just property up to a certain value. Moreover, it should be noted that those who do not have children or whose children do not attend public schools are taxed.

2. Delegate to the Health Administration of HEW and the government Regional Planning and Hospital Review Councils the responsibility for setting such standards of medical and hospital services and for such regional planning and coordination of health facilities as are essential for a satisfactory return on the dollars spent on health care. Like it or not, such planning and accountability are basic to an economical and efficient delivery of health services. Without this, a desirable availability, effectiveness and economy have not been and will not be feasible.

However, such *socialistic* financing of medical care should be clearly differentiated from the *pluralistic,* competitive delivery of health services.

As an advocate of universal national health insurance for 30 years, I wish again [4, 10, 15, 32] to emphasize the importance of maintaining the voluntary initiative and pluralistic competitive character of U.S. 'free enterprise' in the delivery of health services by private and government providers of services. We should and can avoid a monolithic government program of delivering services.

To avoid carrying into Universal National Health Insurance the defects of our current delivery of health services, physicians should take the initiative in:

1. Adapting licensure of physicians to ever increasing specialization. (In a recent oral examination for license to practice in California, the examiner asked me to discuss tumors of the uterus. I replied, 'It would be presumptuous of me to answer this question as I've been practicing pediatrics for 33 years.' Whereupon the examiner said, 'Doctor you are applying for a license to practice medicine.' And the license was granted.)

2. Developing and improving group practice, including group-practice primary family health care.

3. Having specialists hospital based where, with essential allied health personnel and facilities, they are readily available to their hospitalized patients and as consultants in the care of ambulatory patients of primary physicians practicing in neighborhood primary health centers or elsewhere.

4. Minimizing fee-for-service solo office practice, as there develops group practice of physicians and allied health personnel with pooled income from which salaries are paid, as determined by one's group-practice peers.

5. Devising, as recommended by the National Advisory Commission on Health Manpower, means of reimbursing hospitals other than on the current basis of underwriting open-ended, noncompetitive costs with little or no incentive for efficiency or competitive control of costs.

Interestingly, the original plan of Blue Cross proposed prepaying for hospital care on a capitation basis. Each person or family in a community was to choose, with the help of the family physician, the hospital that would provide needed hospital services. Dr. Russell

Lee has advocated this for years [35]. Prepayment would be made for such care. To apply this today, payment might be based on the per person estimated average cost of all hospital services. Thus, if the community hospital elected by a person wasn't equipped to provide certain highly specialized types of service, the patient would be referred to a hospital equipped and staffed to give such service; the first hospital would pay the second from its capitation income. Such payment for hospital service would both lessen the over hospitalization that occurs with most current Blue Cross and other commercial health insurance and should eliminate provision of highly specialized services by hospitals that, in terms of staff, facilities, and frequency of providing service, are not qualified to provide such services.

As mentioned elsewhere [4, 10, 15, 17], the changes in delivery of our health services outlined above introduce nothing new. They are changes now taking place that should be further implemented. With their implementation, the control and return on the universal health insurance dollar spent should be such as to permit this affluent society to make available a single high standard of health care to all, young or old.

The Road Ahead

We've come a long way. But the road ahead may be rough. The way is impeded by obstacles of the past and objections of vested interests. The American Medical Association is advocating National Health Insurance, *but* it isn't advocating needed changes in our way of delivering medical services. Indeed, it is reported that Dr. Annis of the A.M.A. is blocking the appointment of Dr. John Knowles, Internist and Director of the Massachusetts General Hospital, as assistant secretary of H.E.W.

Thank heaven the young people are coming. Hopefully, they have broader and more socially oriented professional interests than their AMA professional elders. Hopefully, they are showing the way to a medical education and delivery of health services that will more efficiently minimize suffering and promote health.

Thirty years ago I wrote, 'Faced with the reality that tax supported medicine is at hand, shall we insist that it be provided economically and efficiently? If we do, health and solvency may be had. One thing is certain—the one cannot be had without the other' [15]. Again we must ask: 'Will we solve the problems that will permit realizing the potentialities of today?'

Oh Baby, tomorrow the eastern sky could be aflame with the dawning of a new day. Or could it be the burning of a city or the fire storm of an atomic bomb?

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42. Each member had a primary physician for primary health and medical care and referral as needed to specific specialists.
43. Requests for reprints should be addressed to: ALLAN M.BUTLER, M.D., Tashmoo Farm, Vineyard Haven, Mass. 02568 (USA).