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The form and financing of medical care in the United States of America

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ANY study of health care systems of the nations of the world can and should begin with reference to the essential element of health care, namely, the relationship between the recipient and the provider of care. This represents a moral, ethical, and legal contract in which the roles of the participants are distinct yet equally important.[1] In such a contract the physician not only agrees to accept the person as a patient but also assumes the responsibility to provide the medical service to the best of his ability. In other words, he should not only perform personally in an optimal fashion but also resist a system that would restrict his best efforts. Specifically, he should not accept depersonalization of roles and diffusion of responsibility which negate the elemental clearly stated and defined patient-physician contract. The recipient not only asks for assistance but accepts it, implying his willingness to pay for service either personally or through an agent. The agent may be an organization such as Blue Cross or Blue Shield, an insurance company, or any of the various departments of government.

These then are the criteria by which any health care system can be judged. First, is health service available and is it good? Secondly, since goods and services have a cost of production, has provision been made for their purchase? If not, is there a failure in the patient role or in the physician role? As the delivery systems and the payment mechanisms become more complex and depart from the elemental relationships between patient and physician, we must, as we are doing at this First International Socio-Economic Conference, examine the form of delivery and the financing of health care to determine whether our goals are being reached satisfactorily or whether there are features of form and financing that impinge adversely on the quality, quantity, and distribution of health care.

Physicians in the United States

The United States is said to have a shortage of physicians. Although this statement is true, it is more a generalization than a precise statement, because the growing availability of other professional and nonprofessional persons in the field of medicine is modifying the need for specific members of the health team. A survey[2] by the American Medical Association entitled

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"Distribution of Physicians, Hospitals and Hospital Beds in the U.S., 1967," completed December 31, 1967, showed that there were 294,072 practicing physicians in the United States. While 274,190 of these were said to be in direct patient-care activity, considerable actual service is provided incidental to the primary functions of the other 19,882 physicians in teaching, in research, and in administration. Of 266,520 active non-Federal physicians, 28 percent were in surgical specialties, 25 percent were in general practice, 23 percent in medical specialties, and 24 percent in other specialties such as pathology, physical medicine, psychiatry, and neurology. Of the total number of active physicians, 24,917 or 9.1 percent were in Federal employ. This circumstance did not deny that they too provided direct patient-care services, as 7,139 physicians were concerned with care of veterans, and 16,136 physicians were taking care of members of the Armed Forces. Of these federally employed physicians, 13 percent were in general practice, 28 percent were in medical specialties, 25 percent in surgical specialties, and 34 percent in other specialties. The number of general practitioners among the Federal physician employees was smaller than among the non-Federal, and the reverse was true in the specialties.

Form of practice

In the United States, as in many countries, there is a mixture of delivery forms. However, in the United States, medical practice has one important characteristic: predominantly it is a private entrepreneurial system in which the provider of health care regards the patient as "his" patient.

By far the greatest number of physicians in the United States in direct patient-care activity practice as individuals or in informal associations. The connotation "solo practice" is inaccurate, because of the propensity of physicians in the United States to associate in informal relationships within an office, or of a tendency to concentrate offices in medical buildings, in shopping plazas, and around hospitals. While it is possible for some physicians to be truly alone professionally without the stimulation of interpersonal relationships, ordinarily this situation does not obtain. Therefore the distinction between solo and individual practice should be given recognition with precise terminology.

There is, nevertheless, a steady increase in the number of formal groups and in the number of physicians in these groups. A survey,[3] conducted by the American Medical Association in 1965, listed 4,289 groups in which 28,381 physicians, approximately 10 percent of actively practicing physicians in the United States, were associated. Of these physicians, 90 percent were in full-time employment. The definition of a group was as follows:[3] "Group medical practice is the application of medical services by three or more *full-time* physicians formally organized to provide medical care, consultation, diagnosis, and/or treatment through the joint use of equipment,

personnel, and with the income from medical practice distributed in accordance with methods previously determined by members of the group."

Groups were divided into three categories on the basis of services provided. (1) *Single-specialty groups:* those that provide services in only one field of practice or major specialty, except groups composed exclusively of general practitioners. (2) *General practice groups:* those composed exclusively of general practitioners. (3) *Multispecialty groups:* those that provide services in at least two fields of practice or major specialty.

Of group physicians, 60.4 percent practiced in multispecialty groups, 31.6 percent in single-specialty groups, and 8 percent in general practice groups. The average number in the groups was 6.6 physicians.

The organizational structure of groups is of especial interest to the physicians in the United States. The majority of groups (77.8 percent) are partnerships; 11.1 percent are professional associations; 8.1 percent are corporations; and 3 percent are owned by single physicians. This last, as I[4] reported in the *World Medical Journal* has some of the characteristics both of a corporation and of a partnership. On the basis of organization, corporations have been criticized by the medical profession because of the opportunity for domination by the laity. Groups generally are suspect if it is not clear that their policy guarantees that a patient himself has the freedom to select the physician to consult. In all fairness, criticism on the basis of any categoric description should be supported by evidence that the structure of the organization or the method of payment for services impairs the quality of care through disturbance of the traditionally correlative roles of the patient and the physician.

Distribution of physicians

American physicians, as is probably the case in every country, are distributed unevenly, in an understandable fashion but without obviously conscious design. The survey of physicians and hospitals of the American Medical Association[2] showed that as the United States becomes more urbanized, greater numbers of physicians, particularly specialists, are to be found in and around metropolitan centers. Urban centers (300 Standard Metropolitan Statistical Areas) contain 85.2 percent of the non-Federal physicians of the country, and 84.9 percent of those who are engaged primarily in patient care. Also, 93.7 percent of hospital-based physicians are in these metropolitan areas. Of the hospital beds of the country, 71.1 percent are in these metropolitan districts where 73 percent of the population resides. Conversely, rural areas have more hospitals that are smaller in size and represent a smaller total number of hospital beds, and fewer physicians, who, for the most part, are engaged in general practice.

Some leaders of thought in the United States believe that there is a strong relationship between distribution of physicians and personnel shortage. They believe, in other words, that if there were a plethora of service

personnel, competition would drive physicians to the less desirable locations where population is less dense and people are fewer in number, or where there is a financial impediment, or an educational and cultural lack of understanding and appreciation of health, or fewer good medical facilities.

To me this expectation has only limited validity. In many cities of the world there is an overconcentration of physicians, and yet peripheral areas go without adequate numbers despite artificial inducements. Old distribution patterns have become obsolete, and a forced distribution pattern will be futile, in my opinion. New and different solutions involving area centers, satellite medical centers, better communication, transportation, and the use of health personnel in allied fields are needed.

Financing health care

Personal resources. Perhaps the greatest differences between national health care customs and systems arise as the result of variations in financing and payment for health care. There may be elements of a financing system that have no peculiar relevance to the quality and amount of care provided. In other instances the care may be jeopardized by the nature of the financing system. To illustrate these points, it is useful to refer to the role and the responsibility of the individual.

In the basic patient-physician contract, and this was the general custom only a few years ago, the patient paid for his health care from his own personal resources. Recognizing unevenness in the abilities of patients to pay, some physicians in the United States gave their services without charge or undercharged, or in the case of wealthy patients overcharged to compensate for losses in regard to the care of those who were unable to pay. This "Robin Hood" arrangement was satisfactory to a limited degree, but the extent of its application was greatly exaggerated in the minds of the public.

Insurance companies. To assist the patient in his role as payer, health and accident insurance was developed by private companies. In the beginning, the principle observed was one of indemnification to make compensation for health expenses, many individuals making contributions to a fund to help the few unfortunate ones who became ill or injured. The incidence of payments and their dollar amounts of this fairly simple insurance were relatively easy to predict in contrast to present-day estimations in areas of unpredictability.

Among the nation's earliest and fastest growing insurance coverage was accident insurance, offered first in 1850 in response to demands for coverage against steamboat and railway accidents of that time. The very earliest was a health insurance company formed in 1847. It is interesting that the principal objective of these early companies was to replace income lost through illness, rather than to reimburse the insured for his payments for surgical and hospital expenses. After a century of primary interest in medical-expense reimbursement, income replacement is now experiencing an upsurge.

Group insurance. Modern health insurance in the United States was initiated in the 1930s, the beginning of a decade of great economic depression. Several stimuli gave impetus to its development. One factor was the recognition of need on the part of providers and recipients alike. Another was the freezing of wages during World War II, and the provision of health insurance benefits in lieu of wages. This was the beginning of group insurance. Other factors contributing to the growth of private health insurance have been increases in the cost of health care, and improvement in the breadth of coverage of the insurance policies themselves.

For the greatest part, both the government and the private health insurance companies in the United States acknowledge and honor the fee-for-service principle. Most physicians believe that this is an essential part of the patient-physician contract, and a keystone of the private practice of medicine. It is a central issue stoutly defended by physicians and their associations. For understandable reasons it is also a prime point of attack by those who would destroy the present system.

Government health insurance. Government participates in the financing of health care in the United States in a number of ways. Whereas municipality and county public health districts provide general health services, their personal health services, largely to the poor, are not of great magnitude or of wide acceptance. Financing is by money collected through taxation at municipal, state, and federal levels, and distribution is largely through public health service channels. Recent Federal legislation for the poor especially, for planning and for Regional Medical Programs for example, indicates a thrust by the Federal Government into greater involvement in the provision of health care. The greatest attention is focused on its two major pieces of legislation, namely Medicaid and Medicare, which are correctly identified as the 1965 Amendments to the Social Security Act of 1935.

Medicaid is an outgrowth or a development of earlier categorical programs of public assistance for the aged, the blind, the disabled, and dependent children. It is financed by matched funds from federal and state taxes, and is administered by the states. An amendment in 1950 provided for payment by the state agency directly to the vendor of service, thus bypassing the paying function of the recipient of care. In 1960, the Kerr-Mills amendment was passed as a compromise to avoid the Medicare-like bill that was then proposed. It was offered for the benefit of aged recipients who were not then enrolled in public assistance programs but who, because of health expenses, might become indigent. It was not satisfactory, largely because the method of determining eligibility for this assistance was considered demeaning by the prospective recipient. In 1965, it was replaced by the so-called Medicaid legislation.

This Act provided for health services for all needy persons (not just those in the four categories listed), with payment for services to be made directly to the vendor by the state agency. Hospitals are paid at cost. Physicians

receive their usual charges consistent with the charges of other physicians in the community for the same type of or similar services. Depending upon determination of eligibility by the individual states, this program will provide for approximately 30 million persons.

The Medicare program included in the same 1965 amendments provided for approximately 19 million persons whose only requirement at first was the attainment of the age 65 years. Ultimately all recipients will have contributed to the Social Security Fund through their employment. Part A of the act provides for hospitalization. Part B is an option wherein the recipient and the Federal Government share an $8.00 per month premium to pay for physician's services. As in Part A, the recipient must pay the first $40.00 to $50.00 of a charge called a deductible, and a portion of the total bill called coinsurance. Since in the Medicare program there is no automatic restriction of payment to the vendor, physicians retain their right to bill the patients directly. The patient then obtains reimbursement from the carrier agent of the Federal Government (usually an insurance agency) to the extent of 80 percent of an amount determined by the carrier to be reasonable,* based on the usual fee of that physician, and other physicians' fees customary in the area.

Private insurance

The greatest number of Americans, however (168 million, a record number increased by 5 million since 1967), are covered by some form of private health insurance. According to a report of the Health Insurance Institute,[5] all 168 million citizens had hospitalization insurance. One hundred fifty-five million of them also had insurance for surgical expenses, 128 million for medical expenses, 69 million for major medical expenses, and 62 million for replacement of income because of disability. These are the major forms of health insurance in the United States. All forms showed growth in the numbers of persons covered by the plan and in the amounts of money paid out.

The total number of persons covered by private insurance represents approximately 84 percent of the population of the United States. These, when added to the 25 percent in Medicare and Medicaid programs plus other direct service arrangements, obviously total more than 100 percent. The apparent discrepancy is explained by the fact that there is duplication of insurance programs. For example, at the end of the year 1967 there were 9 million persons aged 65 years and older who in addition to Medicare had private hospitalization insurance. Others were self-insured, making up from their private resources any deficiencies in Medicare coverage.

Adequacy of coverage for those insured is a valid consideration. Two studies conducted by the Health Insurance Association of America in 1967 provided valuable data. The first, a study of group insurance showed that the basic policy in 99 percent of instances provided hospital benefits for 30

* *The word "reasonable" was used first in its unique capacity in the law, having a distinct definition derived from "usual" and "customary" which were in use before Medicare.*

or more days; 66 percent of the policies had benefits for 70 or more days. While many policies provided more benefit days, it is interesting that the United States Government statistics show that only 3 percent of short-term hospital stays are longer than 31 days.[5] The basic contracts held by 70 percent of persons provide for allowances for surgery of $300.00 or more. Seventy-five percent of persons having group insurance either have a major medical expense provision superimposed or have a comprehensive plan in place of the basic plan.

Plans providing for broader coverage have been developing for a number of years. Both labor and management, representing groups of workers, especially in the automotive industry, are interested in broader insurance coverage. The insurance industry has responded. Perhaps the best means of portraying the present extent of coverage is to list the benefits of a new Blue Shield plan which became available April 1, 1969. The impact of Medicare in shaping the benefits for those insured less than 65 years of age is inescapable of notice.

In a specific policy the coverage includes:

(1) Physicians are paid on the basis of their usual charges, customary in the area. The insuring company pays 80 percent and the recipient (patient) pays 20 percent. Participating physicians agree that there will be no charge to the patient greater than the fee determined to be reasonable according to the criteria in point (1). Additional amounts charged because of requirements of extraordinary care will be satisfied if justified by adjustment of the reasonable charge.

(2) Policy holders will receive the following benefits subject to limitations of availability of the service and to utilization requirements consistent with the amount of premium assigned:

Surgery; anesthesia; radiation therapy; diagnostic roentgenography in-hospital services; laboratory and pathology services in hospital; in-hospital medical care; pulmonary tuberculosis, mental disorders, drug addiction, and alcoholism therapy; obstetric care; emergency treatment for accidental injury; consultation; out-of-hospital diagnostic roentgenography and laboratory service; physical therapy; home and office consultations; newborn care; human organ transplants; dependent children coverage; physical examinations; outpatient psychiatric care; inhalation therapy; ambulance; prosthetic appliances and orthopedic braces; rental or purchase of durable equipment; private-duty nursing; drugs; dental care; vision care.

To recapitulate, payment to physicians of a fee for an individual service, by whatever method of financing, based on usual and customary charges, is the rule in the United States. This report would be incomplete however if it did not mention a voluntary, private, per capita, prepayment mechanism offered by some physicians. Eighty-eight group practice centers engaging about 3,500 physicians have negotiated to provide service on this basis to groups of persons largely employees of industry. The Federal Government

has endorsed this method of health-care financing. The basic reasons for this support are either nebulous or debatable at this moment and cannot be discussed adequately in this paper.

The cost to the United States for health services annually is from 50 to 60 billion dollars. Because of increases in numbers of the population and in demand for service, the amount is expected to go higher. Hopefully the rate of increase in cost will not persist as it has for the years since 1966, the advent of greater spending by the Federal Government for its citizens' health. Continued expenditures in the face of shortages of services cause escalation of prices and cause talk of control of charges, control that may be necessary but which is in conflict with the provider-of-services's visualization of his role as a free private entrepreneur.

The most rapid increase has been in the price of hospitalization, which also accounts for the largest number of dollars spent for health. Control of this expense is attempted through legislation for the encouragement of planning for the construction of inpatient facilities, in which category skilled and custodial nursing homes are included. Also required by legislation is the review by the physician and his peers of the use of hospitals and nursing homes, and the physician's services.

Control of physician's charges is attempted through the carrier of the Medicare legislation and by the promotion of per capita prepayment negotiations with groups of physicians. Prepayment contracts, most American physicians believe, tend to obliterate an important aspect of the patient's role; i.e., his feeling of obligation to pay for at least some part of the service he has requested and received.

To preserve the relationship between the patient and the physician in all that the roles imply, many physicians in the United States have recognized that the resources for the purchase of health care, while enormous in comparison to the resources of the average individual, are finite, and hence expenditures for health have need for limitation. Such physicians have given support to review by their peers and have accepted the challenge to govern expenditures in preference to the imposition of control by the Federal Government.

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