Government, Medicine and the Common Weal*

BARNES WOODHALL, M.D.
Duke University Medical Center, Durham, North Carolina

On New Year's Day of 1939, Robert L. Graves and I, on the way to Montreal, stopped in New Haven to see Dr. Cushing. It was to be the year of his 70th birthday celebration, and the year of his death. I had never met Dr. Cushing; he knew Graves because of a mutual interest in del Río-Hortega's laboratory in Spain. The ensuing conversation was very one-sided indeed until my colleague in desperation indicated that two years earlier, I had been Resident-Surgeon at the Johns Hopkins Hospital. Dr. Cushing turned to me at once and with his enormous personal charm said, "Ah, you and I have slept in the same bed." He was referring, of course, to that hard, wooden-slatted Halsted bed, a substantial honor bestowed upon Chief Residents in those days and certainly this bed was the precursor of the modern conservative treatment of sciatica. It was a delightful morning and near its end, Dr. Cushing turned to me and said, "Are you a member of the H.C. Society?" And I answered, confused but trying to be honest, "Sir, I have never heard of the H.C. Society." In personal extenuation, I must add the fact that I had lived and worked for eleven years on the opposite side of the neurological railroad tracks, engulfed and surrounded by that tradition, much of which has never been fully described. I am confident, however, that you will agree that no one has ever attained this podium in past years from such a lowly beginning and I am very grateful for this honor.

The subject of this address has been announced as "Government, Medicine and the Common Weal" and I realize quite fully that even these bare words may arouse mixed emotions. I would say simply that the traditional doctor-patient relationship represents the final common end point of good medicine and this will always be true. This end point was sufficient unto itself in past decades and indeed past centuries. This is no longer true in the world of today. Economic, social and political changes that are inevitable have vastly altered the approach to this vital end point and the issues are matters of controversy. We must both understand these issues and participate in their solutions in a positive fashion. We must admit further the fact that other and new figures, highly responsible people, have entered upon the stage or the arena of good health, a stage once wholly occupied by the doctor and his patient. The debate is quite comparable to that now forming ranks about "public" versus "private" general education and the question being asked here is this, is higher education the fourth branch of government?21

Nowhere in the history of neurological surgery can some of the issues and problems be documented better than through even a cursory review of the latter years of Cushing's life.

On October 8, 1934, he accepted membership on the Medical Advisory Committee to the President's Committee on the costs of Medical Care. This Committee supported the further use of public funds for preventive medicine and advocated Federal action to aid the building of community hospitals, perhaps the first support by citizens of the concept of the present-day Hill-Burton Bill. The Committee felt that the issue of national health insurance needed further study. Cushing had written to President Roosevelt and suggested a "super-
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bureau of public health” but the President replied that the time was not ripe for such a drastic step, and Cushing returned to his own affairs.4

Some years later, it might be worth while to re-examine this particular scene and to restate the several issues that did concern Cushing to a considerable extent in the later years of his life. In essence these issues have broadened in their social significance and, at the same time, the moment for relevant decision is much closer at hand, being hastened as well by world-wide ideological differences of opinion, and by national issues such as racial equality, both of which carry resounding overtones of control of health. Let me attempt to state these issues in brief form.

1. The concept of comprehensive medical care for the entire population is a basic social right of every individual in the United States.

2. The objective of the total health services is to discharge that obligation.

3. The objective of medical education is to provide the training of the personnel necessary to meet such an obligation of service.

Dr. Willard C. Rappleye, President of The Josiah Macy, Jr., Foundation, has summarized these first three rather simple issues as follows:

“The American people are convinced that adequate health service should be made available to all members of our society and are determined that both the advancement of knowledge and the training of adequate numbers of competent health personnel for their benefit must be supported by the constructive use of their wealth through taxes as well as voluntary channels.”8

Here for the first time today we encounter the ugly word “taxes” and I believe that we can place this word in proper context by changing the title of this address from that of “Government, Medicine and the Common Weal” to “Federal Taxes, State and Local Taxes, Medicine, and the Public Weal.” I make this change purposely before we consider the following basic issues.

4. As of January 1, 1963, some 145 million persons, 79 per cent of the civilian population, were participating in some type of voluntary insurance in prepayment plans, or were themselves otherwise financially stable.

5. As a corollary, at least 23 per cent of the population cannot afford this type of protection and may be classified as indigent or medically indigent, and the economic protection of these groups of the population must be assured, and finally,

6. The voluntary hospital must assume a focal point not only in the care of the protected citizen, but the care of the indigent and medically indigent citizen if the Federal Government’s obvious responsibility in this area is to be satisfactorily answered. The Permanent Administrative Committee of New York City in its report to the Mayor in relation to hospital problems presented another side of the complex matter:

“The Permanent Administrative Committee recognizes the necessity for some controlling body which is empowered to move vigorously and promptly to coordinate all services of the hospitals to meet the community’s needs efficiently and effectively. The time is past when each voluntary hospital can regard itself as a separate entity; each should be an integral part of a broad program to provide necessary medical service to the community at minimal necessary cost.”8

The focusing of attention upon the fiscal plight of the voluntary hospital is of import when studied in relation to the Hill-Burton program initiated in 1946 under the aegis of the Public Health Service. Since 1953, this program, a true marriage of community and Federal responsibilities, has provided 4,604 hospital and medical facilities across this country. These projects, costing a total of 4.2 billion dollars, have received Hill-Burton assistance, that is assistance of the Federal Government, amounting to nearly 1.3 billion dollars. This mixture of public and private initiative is a good example of a concept established in 1798 by representative government that where needs of national health are not being met elsewhere—because of the complexity of the problems, or the insistence of the need, or the magnitude of the resources required—the Federal Government has an obligation to help. The proper adjudication of this concept must always be a bilateral affair between medicine and government,
and this indeed is my main thesis today.

May I briefly review the historical growth of these issues. The dramatic rise of the National Institutes of Health founded in the years between 1937–1944, the developing political debates concerned with elder-care for instance, the growing worry of medical schools supported by large amounts of so-called “soft” money, these and other current affairs seem to many of us to be fresh structures, new philosophies and, of a certainty, substantial threats to our own cups of tea. If we remain immured in only counting our own tea leaves, these changes may well be viewed by us as personal threats. It is an historical fact, however, that similar debates and reasonable adjudication of facts commenced in the new world in health affairs as early as 1730 and was largely patterned upon an English system that had its origin in 1588 and I find these struggles of the past centuries reasonably reassuring.

I quote from the history of the United States Public Health Service as follows:

“The influence of the English system of hospital care for merchant seamen is evidenced by the fact that ‘hospital money’ had been collected in the American colonies since 1730. The seamen of the American colonies were taxed to support the hospital at Greenwich by an Act of Parliament passed in the second year of the reign of George III. Instructions given to Patrick Gordon, Deputy Governor of the Province of Pennsylvania, February 2, 1729, were that the sum of sixpence per month was required to be deducted from the wages of all seamen, English subjects, sailing in and out of American ports”10 (pp. 24–25).

The colonies followed a similar pattern after their independence thus accepting the principle of at least localized compulsory health insurance. The Public Health Service itself is traced to the desire of King George III to charter a group to handle the funds collected to pay for health services for the merchant marine. “There is little doubt that this charter was the basis for the statement sometimes heard in the early days of the Service that the original Marine Hospital Service was founded by King George III”10 (p. 26). I might also add the remark that this was in all probability the first example of so-called “category” medicine, in this case medical benefits restricted to mariners.

In England the idea of compulsory deductions from wages of merchantmen for medical care was adopted some time after 1588, after the defeat of the Spanish Armada. Our law of 1798 required that before a ship would be permitted entry into port, an account would have to be made for each seaman for the time since last entry of a United States port. Out of the wages of each seaman, 20 cents per month were deducted to be paid into the fund for medical care, and “third-party” medicine thus had its origin a very long time ago.

You and I in our generation have lived closely with the more recent social background of the Public Health Service, or to state this theme more broadly and accurately, with all public agencies devoted to health and supported by tax funds. Federal and State Agencies together with the talent of private medicine have discussed and subsequently activated such measures as the control of malaria and venereal disease, the chemotherapy of tuberculosis, the care of the premature infant, the blind, the crippled, the mentally ill or the retarded, the industrially injured individual and a host of others. I point out again that these are all instances of “category” medicine. Government and private medicine have indeed combined resources to aid the veteran, or some other easily identifiable segment of society, but nowhere as yet can one visualize or identify in clear focus any Federal comprehensive health program.

The cost of carrying out these and other programs has been high. It is interesting to see, however, that the percentage of Federal expenditures is still much less than that of expenditures of state-local government and that the projected 1964 budget for all expenditures for public health shows a distinct trend to stabilization. These data are as follows:

“Data compiled by the Department of Health, Education, and Welfare, published in the Social Security Bulletin, November 1962, show the following trends for expenditures for health and
medical care during the 11-year period 1950–61.

"Federal health and medical care expenditures more than doubled, rising from $1.4 billion to $3.1 billion. In fiscal year 1950 these outlays constituted about 3.5 per cent of budget expenditures and in 1961 3.8 per cent.

"State and local health expenditures slightly more than doubled, rising from $1.9 billion to $3.9 billion . . .

"Total public expenditures for health from Federal and State-local sources increased from $3.3 billion in 1950 to $7.0 billion in 1961. Federal expenditures constituted 43 per cent of the total public expenditures for health in 1950 and 44 per cent in 1961. The public expenditure for health, in turn, represented about one-fourth of all private and public health and medical expenditures in both periods.

"Total national expenditures for health and medical care from all sources increased 134 per cent in current prices, from $12.4 billion in 1950 to $29 billion in 1961; as a percentage of the gross national product they rose from 4.7 per cent to 5.7 per cent.

"The long-range trend of Federal expenditures for health in the past has been determined to a large measure by defense needs and veterans' benefits. In fiscal 1950, the expenditures of the Department of Defense and the Veterans Administration for hospital and medical care and construction of facilities for such care were almost $1.1 billion, or three-fourths of the total Federal health and medical care outlay of $1.4 billion. By 1961 expenditures by these agencies for these purposes had risen to $1.7 billion, yet they accounted for a little more than one-half of the total Federal outlay of $5.1 billion for health.

"This trend reflects the progressive emergence in recent years of expenditures by the Department of Health, Education, and Welfare as a major component in the total of Federal health expenditures. For example, direct Federal payments for medical expenses of public assistance recipients, which were not made at all in 1950, had reached a total of $559 million in 1961. Likewise, during this 11-year period medical research rose 11-fold, from $55 million to $586 million, largely as the result of increases in funds for the National Institutes of Health."9

To recapitulate, one, in 1961, total public expenditures for health measured roughly one-fourth of the total national expenditure of health of $29 billion and two, “however, from 1963 to 1964 total health funds will increase by less than $0.9 billion, and the amount for all other agencies except HEW will decline in the net by more than $0.1 bil-

lion.”9 I find it reasonably comforting again that the so-called private practice of medicine is still in business by a factor of three to one and I am curious that the percentage of government involvement is not too far away from the percentage of noninsured people, and granted that there is always more waste in big business, I have a feeling that the Federal government well supports the common weal; on the other hand, state and local governments seem to be denying their own responsibilities. Finally, at this point I would reaffirm the fact that health is the third largest business in the United States, being ranked only by those businesses termed food and transportation. Truly our responsibilities are of a high order of magnitude.

In the past few years, Congress has further passed a research facilities construction act and the so-called HR 12 medical school construction act, combined with loan funds for students. And so with this rather stupendous arsenal of public resources, and with a much larger but more amorphous mass of private resources, we face the six basic issues I have described earlier. Their import is furthered by an awesome growth in medical science, an increase in life expectancy recorded in the first half of this century from 48.2 years to 66.3 years in males,11 a general expansion of population, the expenditure of vast sums of tax money, and a need for more fiscal support; all of these things and others occurring in a large geographic area and among a highly heterogeneous population. Is there any way out of this Pandora box, this welter of perhaps good ideas or bad ideas and certainly expensive notions? I would say there is no way out and indeed this may well be our way of life and we must first of all attempt to understand it. Some small parts of the understanding process is as follows:

Good medicine occurs in the moment of time when a trained physician encounters a patient with a recognizable disease. The physician's training was the summation of philosophies and fiscal resources of at least ten to thirty years ago and what about the patient's illness that cannot as yet be recognized or treated, something we call research?
McGeorge Bundy has probably said these things best of all when his Princeton alumni were alarmed that $22 million out of the $44 million budget of Princeton University was found to come from Federal sources. I would assert again, as he has stated, that Federal support of research and research training and research facilities, always monitored by private medicine and with 50 per cent of costs of construction coming from private resources, has saved the day for this generation of medical schools and for many other university structures. Through this oblique support for medical education, we have been able to recruit young faculty, to give them time and space and economic protection to learn scientific medicine and to make their own contributions to the future of the care of patients. From these people will come the faculties of the new medical schools and those in the clinical sciences will be better physicians than we are. Those in the basic sciences, such as biochemistry and immunogenetics, may well produce some key answers to our many unknowns and we shall leave to the next generation the fact that such answers will further expand the longevity of our species.

Outside fiscal support of considerable segments of the university faculty, first appearing in the physical sciences and medical areas, has bred a new form of dilemma. The university as a social institution has survived all vagaries of church and state since the 12th century, but today the spector of second-class citizenship in the younger components of the medical schools is a very real problem and a new test of what we mean by tenure and university commitment. The inquisitive ones among you may wish to pursue this matter further by reading the report of Harvey Brooks. This describes the pros and cons of the fact that the percentage budgetary support of major universities obtained from Federal sources may range from as low as 25 per cent to a high of 75 per cent.

Typical of the American scene, the pendulum has now swung to support of teaching, teaching facilities and loan funds for students. This younger research faculty can now teach and carry on their business in legal quarters, but it will be many years before an equilibrium will be established in this enormous panorama of support for medical education since the new medical schools should rightfully receive primary support. In this area, private resources are contributing one-third of the costs of construction. The unrequited loan provisions of HR 12, with its low rate of interest, will help our modern medical students adorned with wife and children, and will relieve the medical schools of another harassing burden. I guarantee that the further resolution of these educational matters may well be a hair-raising scramble but it is our responsibility as physicians to understand these matters and exercise our contribution to the intellectual content and control of each separate issue.

Having hastened through these elegant issues at rather a fast pace, let us look again at the plan of the voluntary hospital and the regional hospital. Remember that these hospitals form the backbone of private medicine and I believe that an understanding of their problems, in addition to those noted above, will contribute most of all to an enduring and proper relationship among the factors of Government, Medicine, and the Common Weal.

The point can be made very easily. The fiscal health of this vast array of community hospitals or voluntary hospitals is being threatened by their collective inability to absorb the costs of the proper care of the indigent and medically indigent patient. I am making the assumption that we agree that this is a local responsibility—of medicine and government—and not an isolated Federal responsibility. An example from the State of North Carolina may sharpen this image.

The average cost per patient per day in North Carolina's hospitals is extremely low, that is $27.45. The cost per day in the Duke Hospital is roughly $30.00, both figures being below the national average of $36.83. There is nothing particularly praiseworthy about being below the national average; this fact simply indicates again the fiscal pres-
asures upon voluntary hospitals in many and in certain states. In the last year studied, 1961, care for indigent patients in the State of North Carolina cost the voluntary hospitals $15,050,869.00, of which $11,306,009.00 was paid by taxpayers, at the local level. The remaining $3,000,000.00 was paid for by private patients, another form of unique taxation, or by foundations.

Granted that the voluntary hospital subscribes fully to regional monitoring in all its complex details so that it does not, for instance, compete with every other voluntary hospital, a situation so pithily reported by George Metcalf, then the voluntary hospital should receive full compensation for its quota of the indigent and medically indigent population from local or regional sources of taxes. This is really the nub of the problem, and remains an unsolved issue.

If one could be fully assured that proper medical care was being provided to all individuals even under such disturbing circumstances, the medical community could perhaps learn to live with such a system, but there is considerable evidence that many voluntary hospitals could not maintain fiscal security if they should attempt to care for their fair share, that is perhaps 20 per cent of their load of indigent and medically indigent patients. This fact is clearly shown by the distribution of funds by the Duke Endowment to voluntary hospitals in the States of North and South Carolina. In 1963, the Duke Endowment gave $918,845.00 to 140 hospitals in the two states, representing $1.00 a day for each day of free care. It is interesting to note in passing that 38 years ago when the Duke Endowment initiated these charitable funds, the average hospital cost was $1.00 to $7.00 a day. These days of free care in these 140 hospitals represented 18.2 per cent of the 5,050,091 total days of care, another technique of perhaps measuring the percentage of actual indigent care in these two states. The Duke Hospital received $65,446.00, the next in line $26,429.00, and a local and highly representative community hospital in the city of Durham, $6,303.00. The actual cost of so-called staff patients in the Duke Hospital, both a voluntary and educational institution, that is the operational deficit, was $806,007.00.

In 1962, there were 7,029 hospitals in the United States and 447 of these were Federal hospitals. There were 1,358 state and local government hospitals, 860 proprietary hospitals, 1,017 psychiatric, tuberculosis and chronic disease hospitals and 3,346 voluntary hospitals, the last category representing roughly one half of the hospitals in this country. This last group contains a large part of our educational system and represents the backbone of service to patients of the modern community. I do not know how many of you live your professional lives in voluntary hospitals but I am confident that the 4,704 local and state government and voluntary hospitals possess a common purpose in a determination to insure medical care for all people on a local basis. I say again that one of the keys to good medicine in the future resides in the continuing fiscal health of voluntary hospitals that must accept a full share of the medical treatment of all patients. We have in our own tradition as well much at stake in this particular issue.

I would speak briefly about the alternatives to the main body of this thesis. You know the alternatives as well as I do. I am in no position to debate the social systems of nations abroad or that of our sister country of Canada. It is clear that such systems hope to solve the basic issue of care of health for all citizens at the present moment of time. These countries are in general those with reasonably small populations and some with quite homogeneous populations, dismissing all other possible sources of criticism. I am dismayed at the thought of the manpower that would need mobilization to administer a total health system in this country with its huge and largely heterogeneous population. I am further bemused by the comment made by the Chase Manhattan Bank that "by 1970, there will be approximately one government job for every five jobs provided privately and that by 1980, the rate will stand at over one to four."

An intrinsic American alternative would
be an extension of the existing system of Veterans Administration Hospital, now focused by statute upon the single category of veterans, to the categories of the indigent and medically indigent. Before you blow your tops, as the saying goes, may I point out that the statement has been made broadly that this hospital system has been the main bulwark in this complex world of ours against the more rapid development of so-called socialized medicine. This system has 125,000 beds and in 1961 admitted 566,000 patients, as compared to a national level of 1,600,000 admissions. Over half of its 170 facilities are closely related to the national structure of medical schools. I could live with this alternative granted that the local public-health criteria for the designation of indigent patients were grafted upon its present procedure of admissions. But even a weak critic of this alternative would rapidly indicate the political implications of such a venture.

These two programs noted above can be fairly termed the existing broad alternatives, although categorical and divisive areas of Federal support have been presented, such as that of care of elders, and could quite rightly be discussed. If the voluntary hospital cannot rise to a solution of these issues, then the imprints are obvious, the Federal Government has the obligation to intervene, and it will do so.

In closing a traditional exercise such as this, it is the custom to present certain supporting quotations from the past although I am not at all confident that the past will be very helpful in our present quandary. I am a conformist, however, and I shall follow the custom. Dr. Cushing, with his devotion to the Peter Bent Brigham Hospital, would frown probably upon this quotation from the introductory presentation in the Lowell Institute Lectures of 1963 by Dr. John H. Knowles, General Director of the Massachusetts General Hospital. He said:

"The hospital has now emerged as the 'health center' and provides the platform where the profession meets the public. Its tremendous responsibility is matched by an equally great opportunity as an organized, coordinated social instrument for the study and solution of the social and economic problems which beset medicine and the community today. Medical schools and Staffs of many hospitals have not turned their faces readily to these problems. Health has now become a birthright and the benefits of medical science must be available to all. The public looks with rising expectations to the medical profession . . . , and the hospital finds itself squarely in the middle providing the center stage where all the forces meet."
Hospital Association, and a stronger American Association of Medical Colleges, speaking separately and often negatively and often in open contention, one with the other. May I remind you as an example that John E. Deitrick, Past President of the Association of American Medical Colleges, said a few months ago:

“We recognize the AMA’s right to speak for the profession, but it cannot speak for the medical colleges because of the fundamental differences in the goals I have tried to define.”

If I may use the idea of protagonist-antagonist, why cannot we debate and adjudicate the current issues of medicine with unity and strength, why cannot we become the positive protagonists of the enlightened medicine of which we are capable? Behind these national organizations that I have noted, we have further national professional organizations, such as this one, but we have been mute and we have been another small part of an amorphous protoplasm, often quite invidiously called private medicine. I agree with Dr. Cushing that we do need a Federal super-bureau of health; but we also need a super-bureau for private medicine and how shall we design this unknown structure?

Clichés have been defined as dull, old, truths from which the advanced human mind seeks escape. It is, however, a new fact and an old cliche that there is a fresh era in American medicine. The sentient physician sees in this era the meld of experience gained by our sister countries, an age-old determination and tradition to take care of the needy, an intelligent and forceful interplay between government and private medicine to properly delineate issues, a feeling that the future of medicine may well be more important than its present high level of practice and a determination to come to grips with what Dr. Cushing so aptly termed “difficult problems.”

Neurosurgeons are an elite group in American medicine. We are constantly beset by professional problems about which we really know very little. We work hard but in general society has been kind to us. We live our lives and do our business in the hospital, the centerpiece of medicine. The existence of this institution is beclouded by some of the matters that I have attempted to describe and also I am afraid by our own indifference to these matters. We shall serve the cause of neurosurgery poorly indeed if we do not seek to further understand, aid, and defend the hospital and its next extension, the concept of the regional hospital. We can at least do this much now. It is far too late to do what Dr. Cushing could well afford to do, that is to return to our own affairs.

References