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The Economic Future and Medicine

SIDNEY BJORNSON

There is, at present, a growing discontent among the people concerning the economical aspects of medicine. The terms State medicine, socialized medicine, health insurance, and others, are being bandied about freely in current periodicals, newspapers and medical journals. Because disease "makes good copy" there have been many bizarre stories printed of late. Before a radical change in medical economics should be undertaken, either by the profession of the state, the need for a change should be established.

It has been said that only the rich and the poor get adequate medical care; the rich because they can pay, the poor of charity.

It is estimated that there are three and a half billion dollars spent each year for medical care in the United States, or about 30 dollars per person. This expenditure would appear adequate. However, there is no doubt that the availability of medical services and the distribution of the costs of medical care is improper.

Ability to Pay

The fee system of medical care makes the availability of medical care in direct proportion to the ability to pay. Thus, along with the other effects of poverty, medical care is least available to the class that needs it most, for, curiously enough, the illness disability is highest among the low income groups. Twenty-eight per cent of the low income groups ($1000 or less) and thirty per cent of the people on relief receive no medical care. Certainly charity clinics provide much needed medical service. However, due to lack of funds and overcrowding the charity clinic can properly handle only two general types of cases; (1) emergencies to those unable to go elsewhere, and (2) preventive and control measures.

Middle Class

The above discussion takes no cognizance of the other class of people—those in the medium income brackets, who are not rich enough to comfortably bear high medical costs, and not poor enough to be availed of the charity clinics. These people, who would like to bear their own costs, often do so, but at a cost which most often amounts to a hardship.

Distribution

Inability to pay is not the only factor in the lack of availability of medical services. There appears to be an inadequate distribution of the nation's huge medical facilities. High income states naturally attract more medical men than those of a low income group. Hence there is an uneven distribution of medical service.

Far more regrettable is that cultists, naturopaths, etc., along with patent medicines, attract about 50 million dollars and 15 million people every year.

From the above discussion it would appear that the availability of scientific medical service is inadequate, both as to cost and distribution.

The above facts have caused many people to advance cures for the alleged evils of medicine. These cures apparently resolve into three distinct classes:

1. Complete governmental control and support of medicine (Public Medicine).
2. Voluntary health insurance (Group Medicine).
3. Compulsory health insurance.

Government Medicine

There are not many proponents of unreserved governmental medicine. It seems that such a drastic socialistic move is hardly in step with a democratic form of government. There can be little doubt that an up-standing profession should be as free of politics as possible. However, an observation of political activities would lead to the fear that under state
medicine the profession could resolve into a political football. The cost of administration of such a mass movement would be enormous and might, finally, raise the cost of medical care. There are also fears expressed that the valuable patient-doctor contact that tend to be lost in case of governmental clinics and medicine.

At present there are 185 million dollars spent yearly by the unemployment for care of the indigent and unemployed with plans to greatly enlarge this program.

Voluntary Health Insurance

This proposed plan can be divided into two divisions:
(a) Group hospitalization
(b) Group hospitalization and physician’s service.

Plan A

Group hospitalization is at present in operation in about 60 large cities in this country has about 750,000 subscribers. The mechanics of these plans differ in some ways but in general a few small payments during the year provide hospital facilities and other related features such as: X-ray, laboratory services, etc... Group hospitalization does not, of course, provide for the services of physician. The plan does not provide for the indigent or unemployed but it does leave the patient’s choice of physicians and hospitals.

Plan B

The plan mentioned above could be extended to include physicians’ services but, of course, would demand higher rates. Some medical men have indicated that the plan could be tried experimentally but the main objective raised to the plan is the tendency for the group to limit and dictate as to what physicians are to be called by the subscriber.

Compulsory Health Insurance

This plan is in operation in some foreign countries, mainly and apparently with most success, in England. English conditions are apparently quite well suited for a plan of this nature although some observers are of the opinion that the profession is not benefited markedly. The plan as it is in operation in Britain provides only for the services of a general practitioner and does not provide for specialists' services or hospitalization. All persons employed at manual labor and those with incomes of less than $1250 per year are required to subscribe. Cash benefits are provided for specified periods during illness. The employees pay only 40 per cent of the costs, the employer about 40 percent, and the government pays the remainder.

It would seem that since British and American conditions are so different, it would be wise to try a few small scale experiments before the plan should ever be considered.

Industrial Concerns

Some industrial concerns operate under a similar plan in this country at present and some states do have workmen’s compensation provisions. It is interesting to note that many prominent insurance concerns, privately owned, offer a similar service to the public. Insurance is only a distribution of loss based on reasonably accurate calculations. The loss from illness and the amount of illness that is going on occur can be reasonably well estimated. Hence, health insurance, although no panacea, appears to aid the low income group and will not injure the patient-doctor relationship nor will it invite the invasion of politics into medicine.

Conclusions

There are few conclusions to be drawn on the economics of medicine at present. The logical approach, if a change in medical administration is definitely needed, would be a few studied and well controlled experiments in the different plans of payment for medical services. The medical profession would welcome a solution to the apparent defects in the economics of medicine. It must be remembered that the physician is an individualist, and that he has been so since the days of Hippocrates. A survey of doctors’ incomes shows that the solution is not in the reduction of that income, for during the boom year of 1929, for every physician who received a net income over $10,000,

(Continued on page 54)
A spurious parasite, according to Maurice C. Hall (1), is anything which is not a true parasite, at least in the host in which it is found. For example intestinal parasite ova of chickens can often be demonstrated in the feces of farm dogs who have been eating entrails of infested birds.

The animal showing the largest number of spurious parasitic ova last year was presented to the small animal clinic on November 19. It was a male collie, boarder, about five years old. The dog was brought in suffering from a skin disorder. Scrapings failed to reveal any external parasites and a routine fecal examination was made.

Large numbers of the following sheep parasite ova were observed.

- Nematodirus species.
- Nematode ova resembling Hemonchus contortus.
- Nematode ova resembling Oesophagostomum species.
- Nematode ova resembling Strongyloides westeri.
- Trichuris ovis.
- Cestode ova, Moniezia species.
- Coccidial oocysts resembling Eimeria species of sheep.

At this time no parasite ova of the dog were discernible.

The question was naturally raised as to whether the dog was harboring the parasites or if the ova were being picked up with the feed and were passed through without being digested.

The sample on the twenty-first revealed all the types of ova and coccidia still present. On the twenty-second the sample was negative. The following three days samples were taken and checked but as long as the dog remained in the hospital the feces remained negative for sheep parasite ova.

The owner was questioned as to the habits of the dog and it was learned that the animal had been fed quite constantly off of a floor of the sheep barn. As a matter of routine the dog was returned to the clinic when tape worm segments were found in the feces. Upon administration of arecoline hydrobromide a large mass of Dipylidium caninum was passed but no further evidence of sheep parasites was noticed.

References: (1) Diagnosis and Treatment of External Parasites, Maurice C. Hall.

The Economic Future

(Continued from page 47)

there were two that had an income of less than $2500. It must be remembered that any change in the practice of medicine should be compatible with the interests of the profession as well as the public and the change would preferably come from within the profession.

The costs, and the methods of meeting the costs of medical services are very important. But the paramount importance is the alleviation of illness and its attending hardships and sufferings.

Editors Note: Next issue Mr. Bjornson will discuss the question of state medicine from the point of view of the veterinarian.