

The Committee on the Costs of Medical Care and the History of Health Insurance in the United States

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ABSTRACT

In the early 1920s, the United States began to consider health insurance as a solution to escalating health care costs and as a method for organizing its health care system. The Committee on the Costs of Medical Care was formed to investigate and research potential economic solutions and propose an organizational design. After 5 years of work, it recommended a system where (1) medical services were provided by physician groups, (2) costs were distributed over persons and time using an insurance program, (3) funds and services dedicated to disease prevention were increased, and (4) community agencies coordinated medical care services. However, its recommendations were delivered to a society unprepared to reorganize health care using an economic model rather than the autonomous, industrial model supported by the medical profession.

EARLY SUPPORT FOR HEALTH INSURANCE IN THE UNITED STATES

The concept of health insurance was introduced in the modern industrial world by Chancellor Otto von Bismarck's plan to provide "social" insurance for the working men of Germany in 1883. His scheme, organized through independent sickness funds, was a means, primarily, to stabilize income and provide sickness insurance together with funeral benefits for three-fourths of German's employees, or about one-third of the population. Employees paid two-thirds of the cost; employers paid one-third (Starr, 1982a). Although Bismarck's motives were to wean workers away from socialism, it was the success of his initiative in raising the health level of workers that inspired other nations to follow suit. By World War I, 10 European nations had adopted some form of compulsory health insurance, including the National Insurance Act passed by the British Parliament in 1911 (Bauman, 1992).

In the early twentieth century within the United States, non-government reformers, such as socialists, trade unionists, and progressives, along with a few political leaders, took the initiative in advocating for health insurance. Championed by the American Association for Labor Legislation (AALL) and Theodore Roosevelt's Progressive Party, the first health plan proposals followed the German and British models: placing an

income ceiling on participation and aiming to improve workers' health on grounds of industrial efficiency as well as social equity. Their argument for insurance was constructed around two objectives. First, eliminate sickness as a cause for poverty by distributing individual wage losses and medical costs through insurance. Second, reduce the social costs of illness by providing effective medical care and creating monetary incentives for disease prevention (Starr, 1982b). The program would cover medical aid and sick pay. It would be covered by contributions from employers (40%), workers (40%), and the state (20%). Their concerns appealed to the morals and compassion of the American middle-class as well as the economic interests of the young industrial nation. The AALL campaign was initially quite successful and was able to create a standard health insurance bill based on Bismarck's 1883 sickness funds that by 1917 had been introduced into legislative debate in 12 states.

A number of forces, however, conspired to remove health insurance from the national agenda. Woodrow Wilson's defeat of Roosevelt in the presidential election of 1912 signaled the early end of Progressivism. Health insurance was opposed by the life insurance industry, whose business was directly threatened. Physicians differed with reformers on the program's structure. First, physicians were unwilling to submit to any management by central state or federal public health authorities. Second, physicians did not approve of reorganizing medicine using specialized group practices designed to improve the program's efficiency. Lastly, physicians strongly rejected any form of contract or capitation-payment practices introduced to control costs (Starr, 1982a). The entry of America into World War I, in April 1917, was the most significant deterrent to the proposed program and suspended all discussion of health insurance, leaving most congressional bills unpassed.

HEALTH INSURANCE REGAINS ATTENTION

By the 1930's, with America in the middle of the Great Depression following World War I, health insurance was back on the national agenda. Rising medical costs left not only the destitute and working poor unable to pay for medical services, but also people of more moderate means. Technological advances and more effective training led to an improvement in the quality of services offered by physicians, as well as increased costs. Also,

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physicians began to charge more for their services than was justified by their investment in education, both as a result of licensing restrictions and their intellectual monopoly (Falk, 1977). Due to the increased cost of physicians' services the expense of medical care was rising.

The increasing costs of hospital care had the most drastic effect on medical costs. Over the course of the early twentieth century, the hospital industry in the United States underwent a complete transformation. Before 1870, hospitals were for the chronically ill and indigent, operating on a low-budget basis like charities. However, over time, as hospitals became centers for surgery and acute medical work, their construction and operating costs soared beyond the capacity of donations and generosity. Operating costs now needed to be covered directly from patient fees and hospital charges grew (Rosenberg, 1987). By 1929, hospital costs (not including doctors' and private nurses' hospital bills) were 13 percent of a total family medical bill (Falk et al., 1932), escalating from the 7.6 percent calculated by the United States Bureau of Labor Statistics in 1918 (Ohio Health and Old Age Insurance Commission, 1919). And in 1934, hospital bills and physicians' bills for inpatient services had grown further to 40 percent of total family medical costs. However, this estimate did not reflect the large variance of cost; there were an increased number of exceptionally high hospital bills for a small number of serious illnesses across the population (Davis, 1934). These rising costs alarmed leaders in medicine, labor, and government. The discussion of health insurance was reborn.

THE FORMATION OF THE COMMITTEE ON THE COSTS OF MEDICAL CARE

The objective of health insurance shifted. Now, many of the leading figures in the health insurance movement regarded medical costs as a more serious problem than wages lost to sickness. Public concern grew over the costs and distribution of medical care. President Calvin Coolidge issued a call for research to study economic problems associated with illness. Finally, despite a resolution adopted by American Medical Association (AMA) leadership opposing any government regulated insurance program (Committee on Hygiene and Public Health, 1920), 15 frustrated delegates at the 1926 American Medical Association national convention decided to investigate, and attempt to solve, the organizational problems leading to the rising costs of medical care. They arranged the "Conference on the Economic Factors Affecting the Organization of Medicine" in order to discuss and design a new and innovative system that would improve health care coverage. The delegates exchanged ideas related to medical economics and established a committee that would continue the inquiry and issue a report at the subsequent AMA convention (Walker, 1979). This committee was initially known as the Committee of Five.

The Committee of Five was composed of Dr. Winford H. Smith, Director of the Johns Hopkins Hospital; Dr. Lewellys F. Barker, a distinguished member of the Johns Hopkins Medical School; Dr. Walton H. Hamilton, who at this time was a professor of economics at the Brookings Institute; Dr. C. E. A. Winslow, professor of public health at Yale University; and Dr. Michael M. Davis, former Director of the Boston Dispensary and a prolific writer of articles on the sociological effects of health care. Dr. Smith served as chairman, and Harry M. Moore, an economist with the United States Public Health Service, although not an official member of the Committee, served as secretary (Committee on the Cost of Medical Care, 1929).

Shortly before the AMA's 1927 national convention, the Committee of Five asked Dr. Ray Lyman Wilbur, a past president of the AMA and then current president of Stanford University, to preside at the forthcoming meeting. He led a discussion attended by nearly sixty interested persons, during which the groundwork was laid for the establishment of the Committee on the Cost of Medical Care (CCMC), which would comprehensively study the economics of health care over the subsequent five-year period. Dr. Wilbur was appointed permanent Chairman of the CCMC, while Dr. Moore was appointed Director of Research (Walker, 1979). Members of the CCMC included physicians, public health officials, hospital administrators, dentists, economists, and others. By the time the final report of the CCMC had been issued in 1932, the CCMC had 48 members.

The CCMC was fully independent and obtained funding to cover all of its research and administrative costs through private foundations, such as the Milbank Memorial Fund, the Rockefeller Foundation, and the Carnegie Corporation. In all, 8 foundations donated approximately \$750,000 in support of the CCMC's research over its 5-year lifetime (Falk, 1958). In December 1928, I.S. Falk, then a young medical researcher teaching hygiene and bacteriology at the University of Chicago, was hired as Associate Director of Study. Before Dr. Falk's involvement in the CCMC, only two reports had been published by Dr. Moore. Under Dr. Falk's direction, 23 subsequent major reports were issued on the economic aspects of medical care and the prevention of illness, in addition to 15 miscellaneous reports and 33 reports authored with collaborating agencies.

Dr. Falk reflected on the CCMC's research in a panel discussion 25 years after its final report:

The committee's studies were broad in scope; they dealt with medical care needs, resources, and expenditures; professional and institutional investments, costs and incomes; standards of good care; existing provisions and practices in representative communities; illness, care, and costs among representative families; the costs of medicines and various types of services; ability

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to pay for medical care; and with many special organized provisions to serve particular groups or to enable people to pay the costs (Falk, 1958).

Many of the CCMC's studies from 1927 to 1932 assimilated ideas of the economic organization of the period. The committee was explicit in its purpose: to address the problem of the "costs" of medical care. Costs referred to the fact that middle-class people often could not afford higher-priced technologic and specialty services. In fact, in 1927, the first item on the agenda at the AMA convention was a demand problem: the inability of the people to pay the cost of modern scientific medicine. The supply side of this concern was the crisis in hospital finance. Its proposed solution to both problems was to reform the deficiencies of the present economic organization of medicine (Perkins, 1998). It identified the ultimate question as "What is the best organization for health care delivery, offering the most efficient production of service" (CCMC, 1929). In contrast to health professional discussion, which focused on health insurance as a method for crippling the medical industry and reducing the sovereignty of the medical profession, the CCMC's research described health insurance in terms of economic models and system-wide planning. During its five years of research, and when the CCMC issued its final report, it predominantly focused on the organization and methods of production, rather than the financing of a more efficient medical care system (Falk et al., 1932).

THE FINAL RECOMMENDATIONS

Dr. Falk (1958) summarized the majority's program for constructive action and the minority opinions from the committee's final report, "Medical Care for the American People:"

Majority Recommendations:

1. Comprehensive medical service should be provided largely by organized groups of practitioners, organized preferably around hospitals, encouraging high standards, and preserving personal relations.
2. All basic public health services should be extended to the entire population, requiring increased financial support, full-time trained health officers and staffs, with security of tenure.
3. Medical costs should be placed on a group payment basis through insurance, taxation, or both; individual fee-for-service should be available for those who prefer it; and cash benefits for wage loss should be kept separate.
4. State and local agencies should be formed to

study, evaluate, and coordinate services, with special attention to urban-rural coordination.

5. Professional education should be improved for physicians, health officers, dentists, pharmacists, registered nurses, nursing aides, midwives, and hospital and clinic administrators.

The final report was organized into sections detailing the majority's proposal, along with several minority proposals. It should come as no surprise that the CCMC was unable to reach unanimity for its final recommendations considering its broad composition. However, even though the majority and minority proposals were somewhat distinct, overall, they were closely accordant. The following is the minority proposal which carried the most support:

Minority No.1 Recommendations:

1. Government competition should be discontinued, restricting activities to the indigent, diseases requiring care in governmental institutions, public health, the Armed Forces, etc., and only service-connected veterans' cases (except tuberculosis and nervous and mental disease).
2. Government care of the indigent should be expanded, ultimately relieving the medical profession of this burden.
3. The minority endorses the majority's recommendation (No.4) on coordination of services.
5. Attempts should be made to restore the general practitioner to the central place in medical practice.
6. Corporate practice of medicine should be opposed as: wasteful, inimical to high quality, and unfair exploitation of the profession.
7. Careful trial should be given to payment methods that fit into present institutions and practices.

Minority Report No.1 was in accordance with the majority's recommendations for strengthening public health services (Majority No.2), for coordination of medical services (Majority No.4), and for basic educational improvements (Majority No.5), but it took sharp issue with the proposed organization of medical services (Majority No.1) and on group payments (Majority No.3).

In Minority Report No.2, two dentists expressed their general accord with the main positions of the Majority Report, but joined with the minority in expressing various reservations, especially about group practice and the future position of the professional practitioner, and they endorsed medical care plans sponsored by professional societies. In addition, there were two personal

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statements. Walton H. Hamilton, an economist, criticized the majority report for failures to go further – to make clean cut recommendations for at least compulsory health insurance and for organization of comprehensive medical centers designed to take medicine out of the market place, to revive medical practice as a more truly professional practice, and to return medicine to the status of public service. Edgar Sydenstricker, a public health official, felt that the majority's recommendation did not deal adequately with the fundamental economic question which the committee was formed primarily to study and consider.

In general, the CCMC concluded that even among the highest income group, insufficient care is the rule (Falk et al., 1932), and the basic solution to this problem was to increase the proportion of national resources going to medicine. Starr (1982a) characterizes this recommendation as the beginning of expansionary health insurance—instead of using health insurance to cover existing costs, health insurance could now be thought of as a means of budgeting larger expenditures.

THE AMERICAN MEDICAL ASSOCIATION AND THE COMMITTEE ON THE COSTS OF MEDICAL CARE

There was a great deal of agreement between the CCMC's majority and minority views. The single most contentious point was the majority's third recommendation, calling for the promotion of group practice and group payment for medical care. Interestingly, though it endorsed group payment, the CCMC opposed compulsory health insurance. A compulsory insurance program would require an unprecedented subsidy from government, employers, or both to reach American standards for medical care. Instead, voluntary plans and strengthening of group practice organizations were cited as the desirable first step (Falk et al., 1932). Eight signers of the majority report dissented on this issue alone, arguing that voluntary insurance would later block a compulsory plan and would never cover the poor, who need its protection most. Two others dissented from the entire report. But the sharpest dissent on this point came from the eight private practitioners and one representative of the Catholic hospitals who composed Minority Report No.1. They denounced the majority's promotion of group practice as the technique of big business and mass production, and further projected that such a plan would establish a medical hierarchy that would dictate who might practice in any community (CCMC, 1932a). They argued throughout Minority Report No.1 that government should be removed from medical care in all instances except in the care of the medically indigent and that the general practitioner should be restored to the central place in medical practice. Not only did they reject compulsory health insurance; they denounced voluntary insurance as well, favoring the use of insurance methods only when professionally controlled and

implemented in a system without competition (CCMC, 1932a).

Upon release of the CCMC reports, the AMA characterized the majority's proposal as an incitement to revolution (CCMC, 1932b), endorsing instead the minority faction's proposal (Minority Report No.1). And it was not only the AMA who treated the majority report as a radical document. The *New York Times* (1932) headlined its front-page story: "Socialized Medicine Is Urged In Survey." Headlines in the *Wall Street Journal*, the *New York Herald-Tribune*, and the *Washington Star* issued similar proclamations. The various dissenting opinions from both the left and right gave an impression of discord and virtually undermined any political momentum the CCMC had hoped would generate some consensus for reform. The points of similarity between the majority and the larger minority faction were virtually ignored in the bitter controversy that ensued between the AMA, particularly Morris Fishbein, editor of the *Journal of the American Medical Association*, and the proponents of the Majority Recommendations. The debate became a war of alliances rather than reason. This is best evidenced by Dr. William J. Mayo, one of the founders of the Mayo Clinic, who declared his intention to support the AMA and Minority Recommendation No.1, despite the fact that the Majority Recommendations almost exactly described the then current Mayo system (Walker, 1979). In fact, the AMA's extreme reaction to the majority report left Franklin D. Roosevelt and his advisors, who had just come into office, feeling that to advocate for voluntary insurance was to risky and that health insurance was an issue to be avoided when planning the reforms of the New Deal.

THE EFFECT ON THE HEALTH CARE SYSTEM OF THE COMMITTEE ON THE COSTS OF MEDICAL CARE

The CCMC's Majority Recommendations were quickly lost in the AMA's negative publicity. Instead of a thoughtful discussion of the different proposals, the AMA strongly promoted the first minority's recommendation to its subsidiary medical societies across the nation. Specifically, Dr. Fishbein made a number of personal visits to these society meetings, using Minority Recommendation No.1 to defend the status quo in medical care (Walker, 1979). However, the changing financial landscape of the United States also contributed to the CCMC's ineffectiveness. In the 1920s, when the CCMC formed, persons with a deep concern about social problems were strongly convinced of the value of survey and studies, and had the wherewithal to raise funds to support such projects. They believed that describing the nature and extent of a problem would aid in its solution. The Great Depression changed their thinking. Studies of conditions no longer helped, it seemed. Instead, the immediate problems simply needed addressing, usually through government assistance in the form of federal aid. Thus, reformers'

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energies were invested in promoting government intervention or acquiring financial aid, rather than further defining the problem or its solution. Progressive social reformers and medical care experts predominantly agreed that compulsory, more than voluntary, health insurance was the needed solution. The CCMC's confusing, weak, and somewhat contradictory recommendations on compulsory health insurance further diminished even their supporters' enthusiasm for their remaining recommendations (Walker, 1979).

Despite the CCMC's failure to win popular support, political support, the support of the medical profession, industrial support, or even progressive support, the final report did bring about two changes in practice during its era. First, even though a medical insurance program was not included in the Social Security Act of 1935, that act did provide federal grants to the states for public health service programs—the essence of the second recommendation of the majority's report (Starr, 1982a). Second, in 1937 the movement for voluntary group prepayment of hospital costs culminated in the formation of the Blue Cross program, reflecting elements of the majority's first and third recommendations. In fact, C. Rufus Rorem, a member of the CCMC's research staff, had been appointed to set up the new pre-payment hospitalization plans with money from the Rosenwald Fund, one of the eight foundations that had supported the CCMC over its five year existence (Starr, 1982a).

Historically, the CCMC's endeavor to restructure the organization of medicine has been characterized variedly as an early effort to rationalize medicine economically (Perkins, 1998), as an attempt to use bureaucratic organization to expand access to medical care while increasing professional power (Starr, 1982a), as valuing entitlement to scientific medicine for the whole population (Stevens, 1989), as well as, simply, altruistic (Walker, 1979). However, though the CCMC can be characterized as having been extremely ineffective, time has demonstrated the progression of a number of the majority's ideas and recommendations, in both word and spirit, into existence. Besides the changes which took place within its era, described above, there have been remarkable increases in the quality of and financial support given to all sectors of professional education: physicians, dentists, pharmacists, nurses, and so on, as well as medical research—the majority's fifth recommendation. In addition, there has been significant growth of public services, at the federal, state and local levels, and extension of the services to more of the population, coordinated by a number of different agencies, which reflects the majority's fourth (and second) recommendation. There has also been the creation, and continued growth, of the medical insurance industry, along with the formation of Medicare and Medicaid programs (the majority's third recommendation). Today, almost four-fifths of all citizens are enrolled, at some coverage level, in a health insurance plan. Lastly, and most hotly debated

between physicians today, the recent managed care “revolution” has further changed medical practice, often creating organized groups of physicians with central financial management, though not necessarily associated with a hospital (though often they are)—the essence of the majority's first recommendation. So, although it would be foolish to attribute so many changes (for better or for worse) in health care organization since 1932 to the CCMC alone, it would be an oversight not to credit the committee with some contributions.

Despite its ignoble dissolution in 1932, in retrospect, the CCMC is seen not as some radical group intent on leading a revolution. Instead, it was a thoughtful, deliberate group of social scientists which set out to answer a basic question: how to reform the deficiencies of the economic organization of medicine. Through five years of investigation and research, and in the face of vigorous opposition, the CCMC described its conclusions to an overtly political society that did not function (or respond) as a purely modeled economy, leaving most of their recommendations ignored. However, as time has passed and incremental changes have been instituted, we find that the financial organization of the health care system that was recommended in 1932 by the CCMC is fairly similar to the organization in place today.

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REFERENCES

Editors (1932) Socialized Medicine Is Urged In Survey. *The New York Times*, November 30, A1.

Bauman, H. (1992) Verging on National Health Insurance since 1910. In: *Changing to National Health Care*. Huefner, R.P. and Battin, M.P. (eds.), Utah University Press, Salt Lake City. pp. 29-49.

Committee on Hygiene and Public Health. (1920) Report of Reference Committee on Hygiene and Public Health. *JAMA* 74:1319.

Committee on the Costs of Medical Care (1929) The Five-Year Program of the Committee on the Costs of Medical Care. *JAMA*.

Committee on the Costs of Medical Care. (1932a) *Medical Care for the American People [Report No. 28]*. University of Chicago Press, Chicago.

Committee on the Costs of Medical Care (1932b) The Committee on the Costs of Medical Care. *JAMA* 99:1950-1951.

Davis, M. (1934) The American Approach to Health Insurance. *Milbank Memorial Fund Quarterly* 12:211-215.

Falk, I.S. (1958) The Committee on the Costs of Medical Care—25 Years of Progress. I. Introductory Remarks. *Am. J. of Pub. Health* 48:979-982.

Falk, I.S. (1977) Proposals for National Health Insurance in the USA: Origins and evolution, and some perceptions for the future. *Milbank Memorial Fund Quarterly* 55:161-191.

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Falk, I.S., Rorem, C.R., and Ring, M.D. (1932) *The Costs of Medical Care: A Summary of Investigations on the Economic Aspects of the Prevention and Care of Illness [Report No. 27]*. University of Chicago Press, Chicago.

Ohio Health and Old Age Insurance Commission (1919) *Health, Health Insurance, Old Age Pensions*. Columbus. p. 116.

Perkins, B.B. (1998) Economic Organization of Medicine and the Committee on the Costs of Medical Care. *Am. J. Pub. Health.* **88**:1721-1726.

Rosenberg, C.E. (1987) *The Care of Strangers*. The Johns Hopkins University Press, Baltimore. pp. 237-261.

Starr, P. (1982a) *The Social Transformation of American Medicine*. Basic Books, New York. pp. 235-310.

Starr, P. (1982b) Transformation in Defeat: The changing objectives of national health insurance, 1915-1980. *Am. J. Pub. Health.* **72**:78-88.

Stevens, R. (1989) *In Sickness and in Wealth: American hospitals in the twentieth century*. Basic Books, New York. p. 135.

Walker, F.A. (1979) Americanism Versus Sovietism: A study of the reaction to the Committee on the Costs of Medical Care. *Bull. History Med.* **53**:489-504.

Health care costs have been rising due to more emergency room care, preventable chronic diseases, and aging baby boomers. The ACA slows the rise. The nation's reliance on the health insurance model increased administration costs. A 2003 study found that administration made up 31% of U.S. health care costs. It's twice the administrative costs in Canada. "History of Health Spending in the United States, 1960-2013," Pages 18-22. Accessed Oct. 16, 2020. Medicare's supplementary medical insurance plan (Part B) augments the benefits provided by the hospital plan and is available to most persons 65 years or older. Persons who enroll in the plan pay a small deductible for any medical costs incurred above that amount and then pay a regular monthly premium. If these requirements are met, Medicare pays 80 percent of any bills incurred for physicians' and surgeons' services, diagnostic and laboratory tests, and other services. Almost all people entitled to the hospital plan also enroll in the supplementary medical plan. The latter is financed by general US health care is very expensive. In the absence of insurance, you run the risk of being left without help, or getting a minimum examination only in free clinics. The conclusion of an agreement with an insurance company to purchase a medical policy protects against possible troubles. In addition, according to the recent Affordable Care Act, health care reform, you are required by law to purchase an insurance package if you have been legally living (studying or working) in America for a long time. The cost of health insurance in the United States remains stable for 12 months from the start of sales. Force majeure circumstances give the right to purchase out of time. The price of insurance in the United States consists of several points. A 2017 analysis found the United States ranks 24th globally in achieving health goals set by the United Nations. In 2018, \$3.65tn was spent on healthcare in the United States, and these costs are projected to grow at an annual rate of 5.5% over the next decade. High healthcare costs are causing Americans to get sicker from delaying, avoiding, or stopping medical treatment. The family is trying to raise money via GoFundMe to help cover the costs of Olvera's surgery to remove kidney stones earlier this year, which Olvera was expecting to be covered under a charity program, but was denied and now is stuck with over \$40,000 in medical debt. Susan Finley was found dead in her apartment after avoiding going to see a doctor for flu-like symptoms. Photograph: Courtesy of the family.