I should also note that it was the sense, though not the unanimous opinion, of the committee that the developments they were recommending should come about primarily on a voluntary basis.

It should be remembered that when the committee began its work, in the late 1920s, we were seemingly in a period of great prosperity. The United States was flying toward the highest level of economic affluence and prosperity that it had ever known. It was a period in which there were very strong commitments in a broad spectrum of the population for reliance on voluntarism; people would do things for themselves. Except for the formal field of public health, it was felt that health care was not primarily the concern of government. Instead it was felt that it was primarily a concern of people in their private lives and in the private sectors of their lives. So it is not surprising that these recommendations, except for where public health was concerned, anticipated voluntary, private sector action.

As I indicated, a few members of the committee disagreed. They felt the committee should have stood neutral on voluntary versus governmental activity. They nevertheless went along with the majority. Their views, however, were noted in procedurally agreed-upon footnotes.

The committee's draft report was circulated and studied and discussed. At a general meeting of the committee it quickly became apparent that a minority disagreed very strongly with the recommendations on group practice as the means of providing medical care and on group payment as the means of financing it.

Group practice they regarded as a threat to the independence and the sovereignty of professional people to make their own decisions as to how they wanted to pursue their careers, how they wanted to practice. Group payment was viewed as a threatening challenge to the existence of fee-for-service as the principal means of paying for medical care.

Nine members (eight of them M.D.'s) elected to dissent on those two recommendations as well as, in limited degrees, on others. They wrote an independent report which was published as Minority Report Number One [Appendix C].

Their dissent was based mainly on the notion that the future of medical practice should be left to the medical profession to plan, guide, and control. They did not want dilution of their opportunities and their prerogatives through the participation of lay people.

They also took strong exception to the group payment recommendation unless group payment remained voluntary, was elected by the profession, and remained under the control of the profession through its medical societies. In general, their position was a reflection of the position of the medical profession at that time. They took a position which aimed at pre-

serving the sovereignty–not merely the independence, but the sovereignty–of the medical profession in the field of personal health care.

There was another minority report written by two dentist members of the committee. I won't spend much time on that, because they weren't of one mind. They weren't sure of where they stood, and they wanted to be on both sides of the issue.

There was another major report, called a "statement," written by Walton Hamilton, which I thought was the best economic statement on medical care that had been written up to that point by anybody. He felt the committee had failed to meet its primary obligation because it had made too many compromises in the development of its major recommendations and in the development of the supports for those recommendations. There was also a personal statement by Edgar Sydenstricker in which he took the same position as Hamilton. Sydenstricker did not, however, spell it out.

The majority report, as the formal report of the committee, had the support of a majority of the physicians who were on the committee. The physicians who signed Minority Report Number One were a minority of the total physicians on the committee. That's a point that has not always been clearly understood.

The majority report and the minority reports were released on October 31, 1932, at an important series of meetings at the New York Academy of Medicine.

When the report was released, at the New York Academy of Medicine, there was consternation, because on the table laid out for the press there was also a preprint of an editorial which was to be published in the *Journal of the American Medical Association,* prepared by the then-editor, Dr. Morris Fishbein. In his editorial, Dr. Fishbein damned the majority report of the committee from here to kingdom come. He referred to it in blistering terms, saying that the report and its recommendations were "Socialism and Communism–inciting to revolution." He consigned the majority report to "innocuous desuetude."

There was consternation, and, in a sense, the ceiling fell in on October 31, 1932.

The plans that had been considered for a follow-up organization to publicize the recommendations, to serve to explain them, to assist groups in society to make use of the committee's work-all that went down the drain. They went down the drain because the AMA called a special meeting of its house of delegates and the house formally endorsed the principal minority report [Minority Report Number One].

As a sort of a footnote, I should tell you that by no stretch of my imagination can I conceive of how the AMA could possibly have taken a less productive and less constructive, and a less intelligent position than they took through the pressures on their representatives

on the committee to participate in the development of the Minority Report Number One, or the position they took in their house of delegates in endorsing the minority report. At that time the AMA had a clear choice of a road to follow in the development of the design and the rules under which medical care would develop in the United States.

They had the examples that had been followed by the British Medical Association, by the Medical Association of France, by the medical association in Canada, when confronted with somewhat similar situations. It was as though they were deaf, dumb, and blind–or, their senses apart, they were indifferent to the experience of other medical associations in seeking to provide any constructive or useful guidance. Instead they chose to stand pat and perhaps even be obstructive.

As you can sense, in my view the consequence was disastrous for the whole field of medical care. At that time there was no major group or force in the United States that could play a countervailing role to the AMA and its house of delegates. They were damning the recommendations of a majority of the committee and endorsing the potential monopolistic position of the medical profession, to the exclusion of practically everybody else.

So it came about as ordered from 535 North Dearborn Street in Chicago [AMA headquarters] –except for one important factor. The committee had begun its work in 1927, when the country was rising toward the highest level of economic comfort and affluence that it had known. By October 1932 the country was plunging toward the worst economic depression of recent times. Thus, the committee's work had started in 1927, on the upcurve toward prosperity and great economic resources, but it had ended in late '32, when the country's economy was winding toward a nearly total halt. The "innocuous desuetude" could not be accepted by a nation that was finding itself in very grievous circumstances.

COHEN:[10]

A most significant development occurred when the Committee on the Costs of Medical Care made its report in 1932. At that time Dr. Morris Fishbein was the editor of the *Journal of the American Medical Association* and he wrote a rather significant editorial commenting on the report, indicating that any kind of health insurance proposal was "Socialism and Communism–inciting to revolution." His characterization of health insurance, whether voluntary or public, served to set the dominant ideological and controversial note for some 33 years after that, a third of a century.

During that time, anyone who advocated national health insurance was usually tarred with the epithet of being a socialist or a communist or a radical. It was not until the passage of Medicare in 1965 that those who advocated some kind of a program were able

to overcome that kind of criticism. It was extremely unfortunate, because by injecting that kind of emotional element into the discussion, many of the technical, professional, and substantive issues were overlooked in the battle of the ideological terminology.

It's interesting, however, that Morris Fishbein, before he died, told me that he thought Medicare was a very acceptable and reasonable program and that none of what he said in 1932 had come to pass, at least with respect to the Medicare program.

Morris Fishbein was able later to revise his approach, which some others were not able to do. Nevertheless, it was only with the passage of Medicare that the fateful criticism of socialism–communism was erased. Nobody was socialized or communized by the passage of Medicare, despite the fact that such fateful predictions were made.

The Spirit of the CCMC

Another factor, besides the AMA's stance, that robbed the work of the CCMC of its effectiveness was the despair of the times. Within ten days of the issuance of the report, a complete turnover of political philosophy took place. The inability of the Hoover administration to cope with massive unemployment, bank failures, mortgage foreclosures, and hunger and hopelessness led to the election of Franklin D. Roosevelt as president. Roosevelt promised quick and decisive action, but, despite his massive action campaign four months later, the minds of the people were on basic bread-and-butter issues, with the problems of medical care seeming less urgent.

No matter how despondent the leaders of the CCMC were because their recommendations had been rejected by the AMA, their data and recommendations did have lasting effects. For many years, the data developed by the committee provided a basis for most efforts to reform or understand health care in the United States. Some of the health legislation recommended by the cabinet-level Committee on Economic Security (from whose deliberations Social Security developed) was based on CCMC data.[11]

The data developed in the household surveys, in fact, were the basic source of such information until Odin Anderson instituted a similar household survey at the Health Information Foundation some 20 years later.[12] (Anderson's mentor at the University of Michigan had been Nathan Sinai, a principal in the committee's household survey.)

The five principal recommendations of the committee were ultimately effective in influencing the course of health care. From these recommendations came, in whole or in part, the roots, strong or tenuous, of prepaid hospital care (Blue Cross), the Hill-Burton Act, health care planning, Medicare and Medicaid, and HMOs. The thread started in 1927

thus continues to be spun out.

A few years later, when writing his history of the AMA, Morris Fishbein, editor of the *Journal of the American Medical Association* and reputed author of the editorial opposing the CCMC report, softened his remarks a bit. He said the studies published by the CCMC indicated the value of such studies as a basis for conclusions and recommendations. He recommended continued studies, particularly in industrial medical services and in corporate practice. He said the minority report was "particularly resentful" that the majority made recommendations based on inadequate studies.

Fishbein added that the minority felt that the majority presented the situation in a distorted sense–that the "evils of contract practice are widespread and pernicious."

He charged that the CCMC showed only favorable aspects, that they were chosen because they were thought to be favorable examples of this type of practice in the United States. The minority, in turn, added that for each favorable example "a score of the opposite kind can be found."

Fishbein reverted to the position he had taken in his editorial, in which he condemned the CCMC majority report by using the terms "Socialism," "communism," and "inciting to revolution." He summed up the majority and minority reports in his history by saying that the two represented the "difference between incitement to revolution and a desire for gradual evolution based on analysis and study."

Finally, it should be noted that, while the AMA opposed the committee's recommendations, the American Hospital Association firmly agreed with the recommendation for group prepayment of hospital care. John R. Mannix of Cleveland was actively involved in promoting the hospital prepayment idea, as shown by his work with Blue Cross plans in Cleveland, Detroit, and Chicago. From the 1930s on, Mannix played a major role in shaping the policies of both the AHA and the Blue Cross movement.

MANNIX:[13]

One of the resolutions we offered suggested American Hospital Association activity in what was then called group hospitalization, or periodic payment for hospital care. This resolution resulted in action by the AHA trustees in January 1933 to establish approval standards for hospital prepayment plans and recommended the study by hospitals at the local level of periodic payment for hospital care. This came immediately after the issuance of the final report of the Committee on the Costs of Medical Care, which recommended experiments with the financing of hospital care on a periodic payment basis.

During the next two years, 1933 and 1934, there were seven plans established,

which later became Blue Cross plans and, in my opinion, were the basis of the whole Blue Cross and Blue Shield development.

Following this action of its trustees, the AHA established a group hospitalization committee of five: Dr. Basil MacLean, Dr. S.S. Goldwater, Monsignor Maurice Griffin, Dr. Robin C. Buerki, and C. Rufus Rorem. They strongly advocated local hospitals' establishing programs of prepayment for health care.

The spirit of the CCMC lives on today in pluralistic approaches toward finding a practicable, affordable method, or methods, of insuring all Americans or of finding more than one option, if need be, to solve the problem.

The CCMC also had a lasting influence on patterns of health care research, as shown by remarks of Odin W. Anderson, who became a researcher nearly two decades after the committee's work.

ANDERSON:[14]

I was appointed the research director of the Health Information Foundation in 1952. I was 38 years old with a Ph.D. in sociology from the University of Michigan . . . . My primary interests were in the application of social science research to public policy problems in the health services.

. . . My entry to the health field was through a former staff member of the Committee on the Costs of Medical Care, Nathan Sinai, D.P.H., professor of public health administration, School of Public Health, the University of Michigan, who hired me as a research assistant in 1942, while I was a graduate student at the university. The link between Sinai's connection with the Committee on the Costs of Medical Care and subsequent research conducted in national household surveys by me at the Health Information Foundation is a direct one. It is an interesting example of research continuity. Among the scores of staff members on the CCMC, Sinai was the only one who continued his interest into an academic position. Others, notably Falk, Klem, and Louis Reed, became very active in the Public Health Service. C. Rufus Rorem became active in hospital prepayment and had enormous influence on the development of the Blue Cross system. I, in fact, have always regarded myself as a research descendent–and the only primary one–of the CCMC research base.

Notes

1. Much of the information about the circumstances that resulted in medical education's becoming the subject of the Carnegie study comes from conversations with George Bugbee and John Millis (see Profiles of Participants, in the center of this book, for biographical information).

2. J.C. Furnas, *Great Times* (New York: Putnam's, 1974), p. 175. See also J.T. Flexner, *An*

American Saga: The Story of Helen Thomas and Simon Flexner (Boston: Little, Brown, 1984).

3. Furnas, *Great Times, p.* 174.

4. Eli Ginzberg, *The Limits of Health Reform* (New York: Basic Books, 1977), p. 84.

5. *I.S. Falk, In the First Person: An Oral History*. See Profiles of Participants for biographical information.

6. *C. Rufus Rorem, In the First Person: An Oral History*. See Profiles of Participants for biographical information.

7. *Falk, Oral History.*

8. *Rorem, Oral History.*

9. *Falk, Oral History.*

10. *Wilbur J. Cohen, In the First Person: An Oral History*. See Profiles of Participants for biographical information.

11. The cabinet-level Committee on Economic Security, appointed by President Franklin D. Roosevelt in 1934, was charged with making recommendations on unemployment and old age insurance. Frances Perkins, secretary of the treasury, chaired the committee.

12. For a description of the activities of the Health Information Foundation, see *Odin W.*

Anderson, In the First Person: An Oral History. See Profiles of Participants for biographical information.

13. *John R. Mannix, In the First Person: An Oral History*. See Profiles of Participants for biographical information.

14. *Odin W Anderson, In the First Person: An Oral History*. See Profiles of Participants for biographical information.