The Committee on the Costs of Medical Care

The Flexner report and the work of the Committee on the Costs of Medical Care were major forces shaping today's health care delivery mechanisms.

The Flexner report described the results of a study of medical education early in the century and was published in 1910 under the title, *Medical Education in the United States and Canada, a Report to the Carnegie Foundation for the Advancement of Teaching*. Apparently it came about fortuitously. The Carnegie Foundation was considering supporting a study of the quality and characteristics of the education of members of a learned profession. The first professions proposed for study were law and the ministry, but there were objections or lack of interest on the part of both. Medicine became the third choice.[1]

The timing was fortunate. The AMA had been gathering data on medical education for the purpose of raising the standards of education and licensure, however it did not seem politic for the association to publish a study under its own name. With the foundation financing the study and publishing the findings, the AMA could be helpful in supplying information, and in otherwise assisting in the writing of the report.

Abraham Flexner, a younger brother of Simon Flexner, director of the laboratories of the Rockefeller Institute of Medical Research, was chosen to head the study. In 1886 Abraham Flexner had received his A.B. from the Johns Hopkins University, which was

even then notable for its academic discipline. After his graduation from Johns Hopkins, he returned to his home town of Louisville, Kentucky, and set up a boys' preparatory school which drew favorable attention.

It was in 1909 that Abraham Flexner was chosen to study the medical schools of the United States and make recommendations for their future development. Flexner found the situation deplorable. There were only two university medical schools that required a baccalaureate degree for admission (Johns Hopkins and Harvard), and they sometimes relaxed that requirement. Only 16 out of 155 schools required two years of college, which Flexner believed was the bare minimum.[2]

Many of the medical schools were little more than diploma mills, private schools run for profit. Even the better schools were often little more than lecture sessions, with the lecturers, who were paid a fee, selected from among local medical practitioners. Too often there was little, if any, work done in laboratories and little, if any, instruction in clinical settings. Many of the students were unable to recognize the symptoms of the diseases described in the lectures. The study of basic sciences was generally badly neglected.

One indication of the state of medical education was the failure rate of newly graduated physicians seeking medical positions in the armed forces. Just a few years before Flexner's study, the U.S. Navy had a rejection rate for newly graduated physicians of 46 percent. The Marine Corps' rejection rate was 86 percent.[3]

The Flexner report had widespread repercussions. Higher standards were set for admission to medical schools. The curriculums of medical schools were also changed: in most cases, they began to offer a more thorough grounding in the basic sciences, as well as requiring more laboratory work and clinical training. Many medical schools closed.

What the Flexner report wrought was a revolution in medical education and consequently in medical care.

Eli Ginzberg summed up the effect of the Flexner report:

> In the entire history of this country it is hard to find a more influential social tract than the Flexner Report on American medical education. Released in 1910, this report carefully documented the sorry state of many schools and pointed out the directions for remedial action. These reforms resulted in all future physicians receiving a sound grounding in the biological underpinnings of medicine, in carefully graded educational experiences, and in well-supervised internships.[4]

The genesis of the CCMC can probably be found in the Flexner report. As a result of the report's impact on medical education and the scientific advances that had been taking

place in Europe, American medicine made great strides in the early part of the twentieth century. A by-product of American medicine's rapidly increasing ability to improve the quality of life was specialization, which resulted in fragmentation of the provision of medical care, increasing costs, and a rapid change in the role of the hospital. By the mid-1920s, a number of responsible people began asking questions: What was really the state of health care in the United States? Were Americans receiving the care they needed? How was care being paid for? Were there better ways to provide health care? Would health insurance be practicable on a wide scale?

Out of these and other questions, as well as numerous discussions, came a conference in Washington, D.C., on April 1, 1926. About 15 leaders in medicine, public health, and the social sciences attended. The various problems in the health field were discussed, and it was agreed that a committee should be organized. There was some hesitation, however, about immediately instituting a research program. It was decided that further investigation should be made into the feasibility of a research study. A Committee of Five was appointed to investigate the need. About 75 persons, professionals and laymen, were consulted by mail. The response highly favored research into the economic aspects of medical care.

A second conference was held on May 17, 1927, in Washington, D.C., concurrently with the annual meeting of the AMA. About 60 persons attended the conference, and from them came a nucleus for what was initially called the Committee on the Cost of Medical Care. Aided by universities and professional associations, the committee began in 1927 a five-year study of the state of medical care in the United States: an assessment of where we were, where we were going, and how our movement might be directed. Financing for the study ($1 million) was provided by a group of foundations: the Carnegie Corporation, the Josiah Macy, Jr. Foundation, the Julius Rosenwald Fund, the Russell Sage Foundation, and the Twentieth Century Fund. Grants for special studies were given by the Social Science Research Council and the Vermont Commission on Country Life. (See Appendix A for more background on the CCMC.)

It is interesting to note that two important foundations declined to participate in the finding of the CCMC. One was the Filene Foundation of Boston; the other was the Commonwealth Fund of New York City. These two foundations felt that the answers to the questions which the committee planned to investigate were already known. They offered to support an organization to promote some of the necessary changes, but not to study and rediscover what was going on.

Once the CCMC was organized, Dr. Ray Lyman Wilbur, president of Stanford University, former president of the AMA, and later (1929) secretary of the interior under

President Herbert Hoover, was chosen as chairman. The vice chairman was Charles-Edward Amory Winslow of the School of Public Health at Yale University. Winthrop W. Aldrich of the Chase National Bank became treasurer. The study director was Harry H. Moore, a health economist from the U.S. Public Health Service. Moore had recently completed his doctorate at American University, with a dissertation entitled "Medical Care for Tomorrow."

Winslow was also chairman of the CCMC executive committee, which had eight members, three of them named by the AMA from its top leadership. In addition to Winslow, the executive committee consisted of Haven Emerson, professor of public health at Columbia University; George Follansbee, chairman of the judicial council of the AMA; Walton Hamilton, professor of economics on the law faculty at Yale; Walter Bower and Walter Steiner, distinguished physicians from Massachusetts and Connecticut, respectively; Michael M. Davis, a medical sociologist and economist; and Mrs. William K. Draper, a member of the public.

Total CCMC membership consisted of 50 persons. Members were drawn from private medical practice, public health, institutions, special interests, economics, sociology, and the public. The entire committee met twice a year; the executive committee met twice a month, except in the summer.

Two of the staff people who were active in the CCMC's efforts were I.S. Falk and C. Rufus Rorem. Both men came to the CCMC from the University of Chicago.

Falk had gone to the University of Chicago in 1923 as an assistant professor of bacteriology. He had attained a full professorship by the age of 30. In 1929 he joined the CCMC staff as associate director. From this position, he became the driving force behind much of the committee's work.

Rorem had been on the faculty of the School of Commerce and Administration at Chicago. He joined the committee's staff on a full-time basis in 1930. Rorem focused much of his effort on what were to become landmark studies of hospital capital investment and clinical group practices.

The reminiscences of Falk and Rorem provide not only a history of the CCMC, but also a feeling for the times; not only the committee's contribution to the development of such forces as Blue Cross, Hill-Burton, and HMOs, but also a sense of its ambitions.

Research and Study Program

FALK:[5]

The committee, as you know, had a five-year study program which was to run until 1932. They had planned a whole series of studies to find out how medicine was being practiced, whom it was reaching and serving,

whom it was not reaching and not serving, the costs involved, the sources of the funds, et cetera. Some of the planned studies were library studies. Many, however, were field studies, including extensive surveys of practices by providers of health and medical services, and utilization and financing by consumers. In addition, collaborating studies were planned to be undertaken by such other agencies as: the Public Health Service, the AMA, the American Dental Association, the Milbank Memorial Fund, the Julius Rosenwald Fund, and the National Bureau of Economic Research.

By late 1928 or early 1929, they were, however, encountering difficulties. They had used two or two-and-a-half years of their five-year prospective lifetime and were not well along on what was a very elaborate program of studies. They therefore cast about for some way of strengthening their research undertakings and performance.

Because of some statistical studies I had published in the 1920s and some writings I had done for various journals, I was approached as to whether I might take a leave of absence from the University of Chicago and take charge of the committee's research program. A number of people who were active in the committee knew of my writings and work. Some of them also knew me personally.

At any rate, I was approached. Fortunately or unfortunately, the overture came at just about the time that I was in my most pessimistic mood about the outlook for a school of public health at the University of Chicago. As a result, I was interested.

I went to some meetings of the executive committee and talked with them and they with me about the problems of the committee and its study program. They knew I had something of a reputation of being effective as a director of studies and that I had a fluent pen.

I asked the University of Chicago if I could have a leave of absence. It appeared, however, that I would be gone for two to two-and-one-half years, and they [the university administration] felt they could not approve a leave of that length. So I resigned and became the associate director of the committee, in charge of research.

In passing I should add that this point in time was a troubled period for the University of Chicago. The previous president of the university had retired. A new president had been brought in. However, he had been compelled to resign because of some personal difficulties, and the university was in the process of choosing a new president. About the time I had to make a decision about whether to stay or to leave, the new president came in. However, he wasn't interested in my problem. The vice president was interested in my staying but he was locked into a difficult position by virtue of the financial commitments that had already been made to go ahead with the full development of the Billings Hospital.

The objective of developing a school of public health at the University of Chicago

was essentially scratched. As a result, I found that I was spending a good deal of my time and energy working towards a goal that was not going to be achieved.

So I left.

In leaving, my thought was that I would find it interesting to be extensively involved in the work of the committee. The committee could be a landmark in studying the economic aspects of health and disease and lay out a program for the future. Then, after a couple of years of that, if I found I had other interests, I would turn to them.

Rorem also came to the CCMC from the University of Chicago, where he and Falk had known each other.

ROREM:[6]

In December 1928, while I was teaching as an assistant professor of accounting [at the University of Chicago], I had a conversation with Michael M. Davis, Ph.D. As I'm sure you know, Michael was a medical economist who had just become director of medical services of the Julius Rosenwald Fund in Chicago. He was also a member of the executive committee of the Committee on the Costs of Medical Care.

As part of its work, the committee had been gathering statistical data and general facts about the organization, administration, and resources for health care in this country. They were also beginning to explore some of the financial aspects of hospitals and wanted to add to their staff a person familiar with both accounting and capital investment.

Michael asked me if I could recommend anyone. After some discussion he offered me a temporary, part-time appointment with the committee.

At the outset, I was not a regular member of the committee staff. Instead, I was to work with Michael on a specific study, which was being funded by the Rockefeller Foundation. The study was to examine the amount and nature of the capital investment in the hospitals. No study of this kind had ever been done before in the United States.

The opportunity appealed to me.

I agreed to take the job at the end of the academic year, meanwhile working on a part-time basis through the summer of 1929. Ultimately, I went on the full-time payroll of the committee and moved to Washington, D.C., in January 1930.

Falk, as discussed above, was interested in the CCMC and the challenge of attempting to finish the research on schedule. An extraordinary effort would be required; however, as described by Falk, he and the rest of the committee's staff succeeded.

FALK:[7]

As I said, when I joined the staff, two-and-a-half years of the five years were gone. One or two or three publications had been issued. Five or six other studies that were more or less complete were in the doldrums. A half-a-dozen others were either in an early stage of gestation or had not even been started.

Through 1930 and 1931 we made a great deal of progress. We got the study program on a clearer and better track. We completed a number of the studies that had been bogged down for need of additional or updated information and began to publish our reports on a regular schedule. The executive committee, which met nearly monthly throughout the year, and the full committee, which met twice a year, both gave very intense attention to the reports, which were circulated to them in draft form. It was a very carefully patterned program. The committee was not just a showpiece or window dressing. It was a very extensively and actively involved organization. The executive committee gave an endless amount of time to the reports and meetings.

By early 1932, the study program was sufficiently well enough along so that the committee could see that it was going to complete its study program substantially on time. Twenty-six major reports had been published, or were in press, or being readied for publication, and the staff summary report (to be released as Publication Number 27) was well along toward completion. The magnitude of the nation's health costs had been established–their characteristics, impacts, causes, financing, etc.–and their significance for prevention of disease, diagnosis, treatment, the providers involved, etc. A veritable library of information had been built–a basis for planning had been established.

Falk was responsible for the committee's overall research effort, including the landmark longitudinal household survey. Rorem, while an author of the final staff report (along with Falk and Martha D. Ring), focused his research primarily on financial and organizational issues. His efforts were also quickly productive.

ROREM:[8]

As you can appreciate from the number of publications, the committee's total investigation was divided into several separate subdivisions or study areas. Within this overall structure, my own studies were focused on business operations, on the fiscal and administrative side of medical care production.

My first study, *The Public's Investment in Hospitals,* was issued in November 1930 by the University of Chicago Press, which was the official publisher for the committee.

It's interesting to recall that we selected the study title because our findings showed that 90 percent of hospital capital had come from public sources, about half from philanthropy and half from taxation, and that these sources expected neither repayment of the original capital nor a return in the form of interest.

My second study, *Private Group Clinics,* was published in February 1931. This study, as its name implies, was an examination of group practice among private physicians. It looked at the trend which had been developing for at least 40 years, having its roots in the Mayo Clinic of Rochester, Minnesota.

I was also the author of a volume titled *The Municipal Doctor System in Saskatchewan.* Additionally, I co-authored, with Robert P. Fischelis, *The Costs of Medicine,* a study dealing with the pharmaceutical industry and the use of the prescription drugs and over-the-counter products.

An interesting part of the capital investment study was that many facts and data were obtained by personal visits to institutions. I would ask each hospital for a copy of its financial statement. During the winter of 1928-1929, the first hospital I visited was the Huggins Memorial Hospital in Wolfeboro, New Hampshire, which had 24 *beds,* and the second was the Massachusetts General Hospital in Boston, which had *24 operating rooms.* At neither place was there any record of capital investment. For purposes of insurance, some records were maintained, but neither hospital kept a plant ledger, and management was surprised that anyone should ask for such information.

After a few weeks, and after visiting a dozen more institutions, I found that instead of asking questions I was answering questions. This was a field in which I knew very little, but in which the hospital representatives knew nothing. Within a month I became an expert on capital investment in hospitals and began writing on the subject. There was no literature. If I wanted to read something about capital investment, I had to write it myself.

An example of how little I knew about hospitals was that I did not know that attending physicians at hospitals were private, practitioners using the institutions to carry on their practice. I did not know that very few deans of medical schools in the country received cash salaries for their work. They donated their services, for the most part, and made their living from serving private patients in their spare time.

For example, a statement from the Presbyterian Hospital in Chicago, the teaching institution for Rush Medical College, showed that the medical school paid $500 for the services of the dean of the medical school, Dr. E.E. Irons, who later became president of the American Medical Association.

One day I was speaking with Dr. Irons and said to him, "I find everything in the statement but your salary."

"That's it," he said.

"That $500? You can't live on that."

"Of course I can't, Rufus. That's just for office expenses."

"Well," I asked, "how do you make your living?"

"I have a private practice on the side."

In 1931 I had moved back to Chicago to work on a full-time basis with the Julius Rosenwald Fund, acting as associate director of medical services under Michael Davis. I still, however, continued to serve as a member of the staff of the Committee on the Costs of Medical Care. I was one of the three joint authors of the final staff report of the committee. The others were Isidore S. Falk and Martha D. Ring. Dr. Falk was the primary author; I wrote the section dealing with financial and organizational matters, and Miss Ring served as editor and coordinator of the volume as a whole. [Rorem stayed with the Rosenwald Fund until December 1936, when the fund's trustees liquidated the program in medical economics.]

Final Statement and Recommendations

As the various studies and final staff report approached completion, Falk turned his attention to the preparation of a final statement from the committee itself. There was some question as to how such a statement should be written–whether it should be drafted for the committee or whether the committee should draft it itself.

FALK:[9]

It was decided that the committee was obligated to produce a statement assessing the findings from its studies, providing interpretations, and giving as it thought appropriate recommendations for the future-recommendations which would lay out a program for desirable developments for the future.

As staff, we made some mistakes in our first attempts to draft such a statement or report. That's not of any consequence, because it had no significance for the outcome. Finally the committee undertook to draft the statement on its own. A subcommittee of the executive committee was appointed to act as a drafting committee. It proceeded to draft a report. The draft was then shared with the other members of the executive committee and at a subsequent point with the members of the full committee.

When the report began to take form in the middle of 1932, it was clear that there were five conclusions that had emerged, as the committee saw it, from the studies that had been conducted and which needed to play a role as a foundation for recommendations that they decided they would want to make. The draft report became a summarization and interpretation of the committee's findings and an estimate of the significance of those

findings for the current scene, for the prospective scene, and for the formulation of recommendations.

The drafting committee came up with a report which was titled "Medical Care for the American People, the Final Report of the Committee on the Costs of Medical Care." It's interesting to note that about midway through its work the word "cost" in the committee's name was changed to "costs." This was done because some of the physician members of the committee thought that, unfairly, the public was beginning to think this was just a study of physicians and physician practices. As a result, there seemed to be emerging criticisms just focused on the doctor and the costs of his services. In response to this, various proposals were made to change the title of the committee, to make it clear that this was a much broader undertaking than just looking at the private practitioners of medicine. After considering various alternatives, only one change was made: an "s" was added on to the word "cost." So it began as the Committee on the *Cost* of Medical Care and ended as the Committee on the *Costs* of Medical Care.

The committee's statement, as I indicated, laid out five major recommendations and an extensive text surrounding each. [See Appendix B.] Of these five recommendations, two received particularly intensive attention and precipitated serious controversy.

The first and most important of these was that, because of the developing patterns of fragmented medical care, in the future medical care should be furnished through organized groups of physicians, which would involve generalists, specialists, and supporting ancillary services. Moreover, it also recommended that such groups be organized, preferably around a hospital.

The other particularly controversial recommendation was that, for the future, the costs of medical care should be met by groups of people over periods of time–a group payment concept. This recommendation seems like old hat to us today, but it was not old hat in 1932. It was based on the extensive committee studies which showed that the variable and unforeseeable and, for the individual family, the unbudgetable nature of medical care costs were foreseeable and budgetable for large groups of people–group payment.

In many respects the major recommendations, as subsequent consequences were to indicate, were that the future of medical care should be based on group practice for the availability, the delivery, the provision of care and that group payment, whether by insurance, taxation, or a combination of them, should be the main financial support for the future of medical care.

There were three other major recommendations. One was on the strengthening of professional and technical education. Another was for the strengthening of public health in community activities. The fifth was on the coordination of these various developments.