New Group Health Centers

Three new group health medical care centers, constructed with labor union support, have been dedicated recently in the United States and Canada.

In northeast Philadelphia, a 220-bed hospital, built under the auspices of the city's AFL–CIO Hospital Association at the cost of $6 million, opened in October 1963. It serves the entire community although trade union members are expected to comprise a large proportion of the patients. Planned for many years, the hospital was constructed with the help of a Hill-Burton grant and substantial aid from a number of trade unions in the Philadelphia area. Its circular construction affords a series of centrally located nurses' stations which facilitate nursing care for the 26 patients in the 12 rooms surrounding each station.

At New Kensington, Pa., not far from Pittsburgh, an ultramodern medical clinic building was built to house a clinic owned by the Miners' Clinics, Inc., and staffed by the Russelton Medical Group. This group has long served Pennsylvania coal miners and their families through arrangements with the United Mine Workers Welfare & Retirement Fund. In this new facility the clinic now offers modern medical service to the entire community.

A new Group Health Center at Sault Sainte Marie, Ont., was financed by $135 voluntary checkoff allotments from each of several thousand members of the union of the United Steelworkers of America. The center serves some 15,000 union members and their families. At the dedication on October 4, 1963, the union president, David J. McDonald, pointed out that the Sault Sainte Marie steelworkers have the "proud distinction of pioneering the first consumer-sponsored, prepaid health care plan established by members of our union anywhere on our continent."

The following remarks are excerpted from Mr. McDonald's address.

The problem of properly financing and properly providing the best health care for wage and salary earners has concerned organized labor and management all over North America for many years.

Contract after contract has seen union and management in steel and nonferrous metal industries trying again and again to find the right answer.

As far back as 1958 I can recall being asked to speak to the Medical Society of Pennsylvania on this subject. They wanted an explanation of resolutions we had passed a month earlier at our Atlantic City convention.

I told the society then that organized labor sought a simple goal: a full prepaid system of meeting the costs of medical bills and the provision of the best possible health care in the best possible manner. I went on to point out that for 9 years, even back in 1958, we had tried without success to obtain the cooperation of the leaders of organized medicine in working out such plans.

I pointed out that the union had urged cooperation as the only reasonable alternative to complete government operation of this essential public service. I declared that the barrier to a settlement seemed to us to be "an unreasonable desire on the part of many leaders of medicine to preserve the status quo in medical practice regardless of its consequences."

I pointed out that our union had no quarrel with rising costs of medical and hospital care. I stated that such costs "must increase because of rising standards of wage and salary rates in hospitals, and because our needs of medical care will continue to rise to new heights."

But, as our convention resolution declared, the cold facts were that organizations then underwriting hospitalization and medical care provisions in union-management insurance programs were failing to meet the health care needs of our membership at a reasonable cost and that

the provision of health care was not at a sufficiently high standard level. As an alternative, our convention declared, the union had "found it necessary to investigate the prospect of establishing its own hospitals, clinics, diagnostic centers, and nursing homes and of developing fully prepaid medical care plans utilizing group practice."

Since that time those who resisted change of any kind under any circumstances have seen many of our prophecies come true.

In Canada, universal government hospital insurance is the rule. A similar universal medical care insurance plan has come into being, despite resistance in the early stages, in one Province and is now appearing, in various forms, in other Provinces. In the United States, a plan for universal prepaid hospital care insurance covering all older citizens is a top priority proposal of the present administration and is solidly backed by labor and many other organizations.

There are now, in the United States, numerous examples of union-initiated and community-initiated health care plans. Diagnostic clinics and group health care plans are becoming more numerous. Most significant, our proposals are no longer union-sponsored alone. Progressive management, equally concerned about the problem, has joined with us.

The Group Health Association Center in Saulte Sainte Marie is a further development of this trend. It is the first, but I doubt if it will be the last in Canada.

What are we seeking by this plan?

I think that the first thing we are seeking is to reestablish in the modern industrial community the close feeling of friendship between doctor and patient which we remember from an agricultural past. This is a cooperative plan where medical care consumers share with the medical profession, each in their own field, a common responsibility for the best possible health care.

We can, of course, never return to the exact old-time relationship where doctor and patient lived closely together in a small community, where first names were the rule, where there was no barrier of income differential and, in many cases, no serious barrier of technical language. In our concentrated industrial centers doctors are bound to seek out other doctors in social life. Increasing standards of medical training cannot help but draw a line of technical specialization between the doctor and patient. But we can try to restore, in new ways, the old intimacy once again. We can try, by means of group education and organized activity, to keep social and technical barriers to a minimum.

We want to restore to his proper place the family doctor and general practitioner. We are trying to close the gap of remoteness which all too often puts the specialist into an area of seeming aloofness.

I think the second thing we are trying to accomplish is to liberate the doctor from the worries and technical difficulties of running a business as well as providing service. We say to our doctors: "Let us, your patients, do the worrying about running a business. Your skills and your expensive training demand that you should be free of these concerns, capable of devoting yourselves exclusively to the task of healing the sick and keeping the healthy well. You deserve and shall have a good income, a higher-than-standard income. You deserve and shall have the best possible equipment and the best possible facilities."

I said "healing the sick and keeping the healthy well," and I want to emphasize those words. For, if there is one failing in all private and even universal government-operated medical insurance schemes, it is the fact that they stress payment for treating the sick and, in almost every case, make no provision for keeping the healthy well. This is a key difference in our group health care plans. Here, there is no incentive to concentrate only on healing the sick because that is the only thing that pays. A group health association also provides payment for keeping the healthy well.

Our third concern is to maintain as far as possible the concept of voluntary choice. The doctors who have joined the staff of the Group Health Care Association's Medical Center have done so voluntarily. In so doing, they have increased the number of voluntary choices available to the citizens of the community. The medical care consumers who have formed the association have formed it voluntarily. They have been free to choose either this form of

meeting their medical care costs or of remaining covered by the previous insurance plan. Their decision has been made, not on the spur of the moment, but after long, serious, and detailed study. Even within the association there is individual choice of a family's own physician.

Our fourth objective, of course, is financial. The problem of reasonably controlling the cost of medical care continues to harass unions and management as much today as it did in 1958. The problem remains because the law of supply and demand still applies, and it is a ruthless law. An insurance policy makes all patients rich patients. Costs can rise and standards can rise without let or hindrance. All too often it is merely the cost and not the standard which rises.

The group health association formula permits reasonable cost control. It is just to the physician providing the health care and just to the consumer who receives that health care. Salaries can start at a high level because we want and need the best, but, on that original high basis, the cost of such salaries can be planned in advance. Equipment and facilities can start at a high level because we want and need the best but, on that original high basis, the cost of such equipment and facilities can be planned in advance as well. There is no doubt that, as new high standards become accepted as commonplace, as new techniques for health care emerge and as new cures are found for now uncontrollable ailments, those costs may increase. But they will increase on an orderly, controlled, and negotiated basis. We shall not meet together with management at each new set of negotiations, wondering what the uncontrollable result of experience ratings will force us to take out of the cost of production.

In conclusion, I want to emphasize that this new development is not any exclusively union plan. No such plan could possibly emerge without the statesmanlike cooperation of a progressive management concerned with their social responsibility, nor can any such plan grow and flourish unless it is steadily expanded to serve the needs of the entire community.

PHS Grants for Hospital and Other Construction

Public Health Service grants for construction of research, hospital, and related health facilities during fiscal year 1963 totaled $239,891,203.

Of the total amount, $188,582,119 was for the construction of hospital and related medical facilities. The total of Federal grants under the Hill-Burton program in the 16-year period since its inception in 1948 amounts to about $2.0 billion. These Federal grants resulted in local expenditures of an additional $4.2 billion for the same projects.

The remainder of the $239.9 million—$51,309,084—went toward the expansion of laboratory space in universities and other institutions sponsoring biomedical research. The total amount granted for this purpose by the Federal Government since World War II is $230 million, which, supplemented by non-Federal funds, resulted in the construction of more than $1.1 billion worth of buildings containing research laboratories.

A state-by-state breakdown of the construction grants awarded in fiscal year 1963 has been published as one of a series. Others list research grants and formula grants for health services. Volumes listing funds awarded for training and providing summary tables are planned.