Medical Care Organization and the Law

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PROVISION of adequate modern medical care for its population is a crucial need in the life of any nation. It is only natural therefore that the general public is intensely concerned about this subject and that it is constantly discussed in popular and professional magazines of all sorts. Its ramifications raise issues of many kinds: economic, political, social, and legal as well as moral.

Actually the moral problems are the ones of greatest dimension and complexity. One needs only to speak of "population control" and "euthanasia" to evoke in the listener's mind the picture of the dilemmas in which society is placed. The economic problems are next in magnitude. As medical knowledge progresses, the costs of indicated treatment mount. To be sure, some discoveries, such as the so-called wonder drugs, have had some counterbalancing effects, but, all in all, new techniques whether diagnostic or therapeutic tend to enhance the overall cost even on a fixed base, that is, by eliminating the effects of inflationary forces that actually operate on both sides of the ledger—on the medical expenditures as well as on the patient's financial resources. Most of all, the great shifts in the population composition of the United States are sources of disquiet in the economic picture. Constant decrease in the mortality of the age group 1 to 18 years old as well as the pronounced prolongation of the nonproductive years following retirement have significantly affected the economic aspects of the provision of medical care.

Table 1, culled from data published by the Social Security Administration and the Bureau of the Census (*1*), shows, for the period between 1900 and 1980, what percentages of the total population were or are estimated to be under 20 years or over 65 and thus demonstrates the increasing burden placed on the productive group as a result of the needs of the nonproductive groups.

In appreciating the full significance of these figures one must keep in mind that not only has the percentage of the total population in the over 65 age group more than doubled since the beginning of the century but that the medical needs of that group greatly exceed those of a similarly sized group in the lower age brackets.

The advances in medicine calling for the services of an ever-increasing array of specialists and the corresponding aggravation of the difficulties for large parts of the population to provide, by means of their own, all needed medical services have wrought great changes in the organization and the financing of such services. As a result, the formation of permanent groups of different medical specialists and the establishment of prepayment plans on a distributive basis became inevitable.

However, in order to accommodate the needed changes, the famous professional twin "taboos" had to be broken or at least redefined: the ban against contract practice and the ban against the corporate practice of medicine. In addition, the development of group medical cost insurance (group health insurance) altered the situation radically.

Eclipse of the Two Taboos

Organized medicine was originally adverse to the establishment of prepayment plans, taking the view that they violated the time-

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honored interdicts against contract practice and corporate practice of medicine. Actually both these principles rested on rather precarious bases.

It is not intended to rehearse the story which others have told so often and so well (*2*, *3*). Suffice it to say that the prohibition against corporate practice of medicine was implied by the courts from the licensing provisions in the medical practice acts, which go back to the recognition and regulation of the medical profession as a learned and privileged craft through legislation which originated in the late colonial period and the early days of statehood. An act to regulate the practice of physics and surgery, passed in 1797 in New York, was apparently the first such statewide statute (*4*). Massachusetts enacted similar legislation in 1817 (*5*). California, however, in 1937 did insert an express formulation of the proscription into its legislation (*6*), subsequently soft-pedaling it somewhat by authorizing dispensation, in the discretion of the Board of Medical Examiners, for the salaried employment of physicians and surgeons by charitable institutions, clinics, and medical schools (*7*). The reason for the adverse attitude of the legislatures, courts, and, above all, the medical profession itself was the apprehension that arrangements whereby profit-oriented business enterprises, by contracting to supply medical services to be rendered by employed medical personnel, would commercialize medicine and thereby impair the standards of care and the independent judgment of the attending physician as well as the economic and social status of the profession.

Various decisions by courts have echoed these concerns. In the celebrated Illinois case of *People* v. *United Medical Service* (*8*), the Supreme Court of that State upheld a judgment of ouster in quo warranto proceedings brought by the attorney general of that State against a fixed-fee, low-cost medical service clinic, organized as a business corporation for profit, observing:

> [T]he practice of a profession is subject to licensing and regulation and is not subject to commercialization or exploitation. 'To practice a profession . . . requires something more than the financial ability to hire competent persons to do the actual work. It can be done only by a duly qualified human being, and to qualify, something more than mere knowledge or skill is essential. . . . No corporation can qualify, ... We find nothing . . . which conflicts with the well-established rule that the State may deny to corporations the right to practice professions and insist upon the personal obligations of individual practitioners.

Table 1. Actual and estimated population composition of the United States, 1900–1980

Year	Total population (thousands)	Under 20 years (thousands)	Percent	Over 65 years (thousands)	Percent
1900	77, 229	34, 281	44. 4	3, 124	4. 0
1910	93, 781	39, 394	42. 0	4, 016	4. 3
1920	108, 070	44, 730	41. 4	4, 973	4. 6
1930	125, 497	47, 365	37. 7	6, 691	5. 3
1940	134, 974	53, 439	39. 6	9, 047	6. 7
1950	154, 854	63, 104	40. 8	12, 308	7. 9
1960	180, 677	69, 596	38. 5	16, 658	9. 2
1962	186, 591	73, 095	39. 2	17, 308	9. 3
1970	214, 222	86, 658	40. 5	20, 035	9. 4
1980	259, 584	108, 802	41. 9	24, 458	9. 4

Other courts took a similar approach. A further good illustration of the prevailing attitude is *People* v. *Pacific Health Corporation* (*9*). In that case quo warranto proceedings were brought against a business corporation, operated for profit and engaging in contracts whereby it assumed, against payment of a fixed premium, to pay for hospital, medical, and allied services, rendered, on a fee basis, by physicians selected from a list kept by the corporation. The State Supreme Court upheld a judgment of ouster, rejecting vigorously defendant's argument that the physicians, engaged on a fee basis, were independent contractors. The opinion stated (*9a*):

> The evils of divided loyalty and impaired confidence would seem to be equally present whether the doctor received benefits from the corporation in the form of salary or fees. And freedom of choice is destroyed, and the elements of solicitation of medical business and lay control of the profession are present whenever the corporation seeks such business from the general public and turns it over to a special group of doctors.

However, the court carefully limited the scope of its interdict by specifically differentiating cooperative provision for medical services on a nonprofit basis (*9b*) because there "the doctors are not employed or used to make profits for stockholders . . . and since the principal evils attendant upon the corporate practice of medicine spring from the conflict between the profes-

sional standards and obligations of the doctors and the profit motive of the corporation employer, it may well be concluded that the objections of policy do not apply to nonprofit institutions."

There were, however, occasional discordant notes. Thus an earlier decision in Missouri affirmed a denial of ouster, sought in quo warranto proceedings against a corporation which entered into contracts to supply medical treatment for hernia and employed its principal stockholder and manager, a licensed physician, for that purpose (*10*).

The medical profession, to the extent that it was represented by the American Medical Association, took a similar stand, focusing primarily on the aspects of "contract practice." Its professional code, entitled "Principles of Ethics," which in the course of time has undergone many transmutations, began dealing with the subject in the revision of 1912 (*2a*). Under the heading Contract Practice, it stated:

> It is unprofessional for a physician to dispose of his services under conditions that make it impossible to render adequate service to his patients or which interfere with reasonable competition among physicians of a community. To do this is detrimental to the public and to the individual physician, and lowers the dignity of the profession.

In 1934 this canon was enlarged so as to set forth in greater detail the definition of "contract practice" and, by way of illustration, a list of features or conditions which would render a contract unethical (*2b*). The catalog specified the following seven proscriptions:

1. When there is solicitation of patients, directly or indirectly.
2. When there is underbidding to secure the contracts.
3. When the compensation is inadequate to assure good medical service.
4. When there is interference with reasonable competition in a community.
5. When free choice of a physician is prevented.
6. When the conditions of employment make it impossible to render adequate service to the patient.
7. When the contract because of its provisions or practical results is contrary to sound public policy.

This catalog remained part of the "Principles of Medical Ethics" until their revision in 1949. At that time the contract practice ban was recast so as to read (*11*):

> Contract practice per se is not unethical. Contract practice is unethical if it permits of features or conditions that are declared unethical in this Principles of Medical Ethics or if the contract or any of its provisions causes deterioration of the quality of the medical services rendered.

In addition, the "Purveyal of Medical Service" section proscribed "disposition by a physician of his professional skills to any hospital, lay body, organization, group, or individual . . . under terms and conditions which permit exploitation of the services of the physician for the financial profit of the agency concerned."

This change in the "Principles," as well as some of the indulgent words in the judicial decisions reflect the changes which meanwhile had been wrought by legislatures as a result of public pressures for recognition of prepayment, risk-distributive arrangements.

Prepayment Plans Come of Age

In the late twenties the efforts to provide for medical care and hospitalization on a cooperative prepayment basis or by means of insurance gained new impetus and finally led in many States to legislative action.

Hospital service plans sprang up in many parts of the country, such as Cleveland, Dallas, Sacramento, Charleston, Newark, New York, and St. Paul, many of them on a multihospital, free-choice basis (*12-14*). Because of certain questions that arose under the State insurance laws, enabling acts permitting the establishment of nonprofit hospital service corporations were passed, first in New York in 1934 (*15*) and subsequently in many other States (*12a*). In Ohio it was discovered that limited authority existed on the basis of a statute that actually had been passed in 1903 (*12b*). The restrictions were removed by a 1939 statute (*16*). The American Hospital Association endorsed prepayment plans in 1933 and established in 1937 a committee on hospital service which, with two intervening stages, became the Blue Cross Commission in 1946 (*12c, 13a*).

Cooperative medical service plans for partic-

ular employee groups gained prominence in the same period. The Ross-Loos Medical Group in Los Angeles and the King County Medical Service Bureau in Washington State became famous examples (*17*). In the early and mid-thirties the Michigan and California State medical societies decided to make an extensive study of the situation in their respective States and ultimately sponsored enabling legislation for prepaid medical care plans in the form of a nonprofit corporation (*18*). The California act, adopted in 1941 (*19*), authorized professional nonprofit corporations provided that at least one-fourth of the licentiates of the particular profession become members. The Michigan statute of 1939 (*20*) provided for the incorporation of nonprofit medical corporations, provided that the board of directors include members of the medical profession and that the majority of the board be persons approved by the officers of the medical societies. The California act led to the creation of the California Physicians' Service.

The majority of other States passed analogous legislation; a list can be found in the article by Hansen (*3a*). Washington, although an early pioneer, delayed legislative action until 1947, when its Health Care Service Agreements Law was passed (*21*). In that State, as in some other jurisdictions (*3b*), no requirement for effective control by the medical profession was inserted into the legislation. The Washington statute was referred to in the celebrated case of *Group Health Cooperative of Puget Sound* v. *King County Medical Society*, in which injunctive relief was granted against discriminatory measures taken against the physicians affiliated with the cooperative (*22*). Prompted by the legislative success, the AMA in 1944 actively entered the sponsorship of such plans. As a result, a national coordinating agency, Associated Medical Care Plans, with the Blue Shield as an emblem, was created in 1945. (*23*).

Of course, the new legislative sanction created immediately a host of fresh legal and policy problems. One question concerned the existence of supervision by the insurance commissioner. In California, this question had not been settled by the act and thus the State Supreme Court in *California Physicians' Service* v. *Garrison* (*24*) had to resolve the issue. The court decided the question in the negative, relying heavily on *Jordan* v. *Group Health Assn.* (*25*), a case arising in the District of Columbia which had reached a similar conclusion. The court distinguished the prior case of *Maloney* v. *American Independent Medical & Health Assn.* (*26*) in which it had been held that a nonprofit organization operating on a reimbursement basis did engage in health insurance. Another litigation in California involved the question whether group health plans outside of California Physicians' Service could be organized in the form of a nonprofit corporation (*27*). The Supreme Court answered in the affirmative, relying on a D.C. precedent (*28*) and disapproving to that extent the District Court of Appeals decision (*26*) that had reached the opposite conclusion. The Kaiser Foundation Health Plan, inter alios, appeared as amicus curiae. As a result, the permissibility of cooperative medical care and hospitalization service plans on a fixed prepayment basis became firmly established, but variations exist as to the need for medical society sponsorship or the subjection to supervision by the insurance commissioner.

Expanded Activities of Commercial Firms

Favorable public response to the protection programs of the service plan organizations, especially the Blue Cross-Blue Shield groups, spurred the commercial insurance carriers to greater activity in hospitalization and medical expense insurance. Health insurance had been written since the beginning of the century. The principal benefits under policies of that kind, however, consisted of loss-of-income benefits, although some coverage of hospital and surgical expenditures was included. During the thirties and forties two major shifts occurred; coverage of the costs of hospitalization and medical care became the primary feature of the insurance, and group insurance entered the field and showed a fabulous growth. The early history of these developments has been detailed by Miller and others (*29*, *30*). This trend, of course, was mainly due to the recognition of health benefits as a legitimate object of collective bargaining by the National Labor Relations Board.

The insurance industry found in the expand-

ing field of health insurance a great challenge and opportunity and responded with cooperative action. In 1956 the major carriers, both life and casualty companies, formed the Health Insurance Association of America. In addition, eight trade associations in the insurance field established in 1946 the Health Insurance Council to serve as a liaison agency between the dispensers of health services, such as physicians and hospitals, and the underwriters. The original sponsors of the council were the American Life Convention, American Mutual Alliance, Association of Casualty and Surety Companies, Bureau of Accident and Health Underwriters, Health and Accident Underwriters Conference, Life Association of America, Life Insurers Conference, and the National Fraternal Congress of America. In the course of time the National Fraternal Congress dropped out; two other organizations, the Association of Life Insurance Medical Directors and the International Claim Association, joined; and the Bureau of Accident and Health Underwriters and the Health and Accident Underwriters Conference were merged in the Health Insurance Association of America (*30a*).

Since 1948 the Health Insurance Council or a predecessor committee has published annual surveys of voluntary health insurance coverage in the United States, which demonstrate the tremendous growth of this kind of protection and the rising share of the commercial carriers in the total of the persons covered. Differentiating between hospital, surgical, and regular medical expense coverage, the surveys estimate that, allowing for duplications, the number of persons having these kinds of protection, either as primary beneficiaries or dependents, has undergone a tremendous expansion between 1947 and 1962 (table 2).

Table 2. Persons covered by voluntary health insurance

Year	Hospitalization (thousands)	Surgical expense (thousands)	Regular medical expense (thousands)
1947	52, 584	26, 247	8, 898
1952	90, 965	72, 459	35, 670
1957	121, 432	108, 931	71, 813
1962	141, 437	131, 185	98, 204

Table 3, which shows the percentage share of coverage among Blue Cross-Blue Shield, commercial carriers, and independent service plans, reveals that the commercial insurance companies consistently held more than 50 percent of the total market in the field of surgical expense coverage, preserving a fairly stable share over the 15-year period. The commercial carriers made other impressive gains, outrunning the Blue Cross-Blue Shield systems in hospitalization coverage and making the greatest progress in regular medical care protection. These advances were mainly due to the growth of group insurance (table 4).

Corresponding to the growth in coverage is the increase in annual benefit payments which are reported since 1952 (table 5).

There can be no question that voluntary health insurance today constitutes a very important means of social protection. It is imperative, therefore, that this protection be provided in a responsible and economic manner.

Table 3. Percentage distribution of coverage among various organizations

Year	Hospitalization			Surgical expense			Regular medical expense		
	Blue Cross-Blue Shield	Commercial insurers	Independents	Blue Cross-Blue Shield	Commercial insurers	Independents	Blue Cross-Blue Shield	Commercial insurers	Independents
1947 [1]	52. 3	40. 7	7. 0	26. 3	59. 4	14. 3	33. 0	24. 5	42. 5
1952 [1]	43. 4	51. 3	5. 3	34. 7	59. 3	6. 0	48. 0	38. 1	13. 6
1957	42. 3	54. 0	3. 7	38. 4	56. 9	4. 7	48. 5	43. 6	7. 9
1962	39. 6	56. 4	4. 0	36. 5	57. 7	5. 8	46. 4	45. 5	8. 1

[1] Not adjusted for duplicate coverage with commercial carriers, therefore percentages are slightly inflated.

Proper supervision of the various insuring organizations in order to protect the public against excessive rates, disastrous disruptures, or misleading coverage clauses is therefore a matter which requires most careful study (*31*).

The Share of Public Programs

Although the total of about $6.2 billion paid out in 1962 for hospital, surgical, and other medical expenses covered by voluntary prepayment arrangements constitutes an impressive figure, it becomes meaningful only if projected against and compared with the additional sums that are paid for the same purposes. These are the funds paid (*a*) by the patients themselves under direct contracts with the suppliers of such service, in particular hospitals and physicians, and (*b*) under social security or other public programs.

The Social Security Administration, through its Division of Research and Statistics, has developed techniques for collecting and analyzing data relative to the consumer expenditures for medical care and voluntary health insurance (*32*, *33*) and for measuring them against the total social welfare expenditures (*34*).

Table 6, based on the division's data (*33a*), which vary slightly from the data published by the Health Insurance Council reproduced before, indicates development of the private financing of medical care expenditures. The table shows that prepayment arrangements now cover 54.6 percent of the private expenditures for physicians' services, 72.1 percent of the expenditures for hospital care, but only 31.1 percent of total private expenditures for all health care needs.

The picture is still different if account is taken of the expenditures for the same purposes made under various public programs, including the social insurance systems.

Excluding public expenditures for medical facilities construction, medical research, and public health activities, expenditures for direct medical care defrayed by social insurance or other public programs are given in table 7. The foregoing survey shows that the provision of medical care financed under social security programs, such as workmen's compensation legislation, State temporary disability insurance, or government assistance programs, amounts to a major factor in meeting the nation's medical care needs. In round figures, it appears that the total met needs amounted to $27 billion, of which $7.5 billion were covered by voluntary insurance and $6.0 billion contributed by government-sponsored programs, while the other half was paid for on the individual service contract basis.

Of course, these data cover only met needs. They do not show the unfilled needs nor disclose whether this method of responding to medical care needs does not actually cause the needs of certain population sectors to remain unmet or not properly met.

A Tentative Prospectus

There seems to be agreement on the proposition that at present that segment of the population which has the most extensive health care needs possesses less insurance protection than the groups with less costly health requirements; the aged portion of the population is exposed to the greatest lack of insurance coverage (*14a*, *35*). Likewise it seems to be generally admitted that the premium or rate structure of health insurance is the decisive factor in that picture. Spreading the cost of health insurance for the aged over the aged population alone will not be of assistance. As Lear (*14b*) has shown, company-pooled "over-65" policies as are made available under the so-called Connecticut plan (*36*) and legislation following that model (*37*) offer no panacea. In some form, the costs of prepaid or assured health care services for the aged must be subsidized through some mechanism which shifts a portion of the costs to other population components.

Of course, one might be inclined to think that this conclusion could be obviated by a system which provides for long-range health care protection on a level premium basis and supplies the premium deficiencies occurring in the later life of the policy through a reserve built up by excess premiums paid during its early years. But it is questionable whether such a form of policy or certificate, which would have to be protected against cancelability and endowed with a discontinuation value, as well as built-in anti-inflationary hedges, would be economically

feasible, especially on a group basis with continuation privileges (*14c*). Moreover, issuance of such policies would require some statutory clarification of the "adequate and not excessive" clauses in the current rate regulatory laws to the extent that they are applicable to the insuring organization. In any event, the availability of this kind of protection would not alleviate the plight of the present generation of the aged population.

A substantial portion of the costs of health care coverage of the older population, therefore,

Table 4. Distribution of hospital, surgical, and regular medical expense coverage, by type of insurance organization, 1947–62 (thousands of persons)

Year	Commercial insurance carriers								
	Hospital expense			Surgical expense			Regular medical expense		
	Group policies	Individual policies	Adjusted total [1]	Group policies	Individual policies	Adjusted total [1]	Group policies	Individual policies	Adjusted total [1]
1962	59, 153	36, 061	85, 174	59, 787	31, 443	81, 983	40, 012	10, 974	47, 010
1961	57, 013	33, 874	81, 369	57, 373	30, 402	78, 861	38, 003	10, 117	44, 399
1960	55, 218	32, 902	78, 885	55, 504	28, 209	75, 305	35, 802	8, 902	41, 312
1959	51, 255	31, 718	75, 457	51, 756	27, 456	72, 263	32, 469	8, 582	38, 227
1958	49, 508	29, 372	71, 798	49, 917	25, 819	69, 125	29, 868	7, 869	35, 142
1957	48, 439	28, 673	70, 192	48, 955	24, 928	67, 456	28, 317	7, 371	33, 240
1956	45, 211	27, 629	66, 259	45, 906	23, 074	62, 996	25, 177	6, 789	24, 756
1955	39, 029	26, 706	59, 654	39, 725	22, 445	56, 645	20, 678	6, 264	25, 031
1954	35, 090	25, 338	55, 282	35, 723	21, 442	52, 806	15, 778	6, 513	20, 721
1953	33, 575	24, 911	53, 482	34, 039	21, 625	51, 707	13, 787	6, 008	18, 523
1952	29, 455	22, 254	.....	29, 621	19, 196	.....	10, 157	5, 118	.....
1951	26, 663	21, 574	.....	26, 621	16, 395	.....	7, 946	4, 230	.....
1950	22, 305	17, 682	.....	21, 219	14, 104	.....	5, 587	2, 714	.....
1949	17, 697	14, 729	.....	15, 590	9, 315	.....	2, 736	2, 350	.....
1948	16, 741	11, 286	.....	14, 199	6, 934	.....	1, 927	1, 810	.....
1947	14, 190	[2] 7, 585	.....	11, 103	[2] 4, 875	.....	1, 098	[2] 1, 111	.....

Year	Blue Cross-Blue Shield and medical society plans			Independent plans		
	Hospital expense	Surgical expense	Regular medical expense	Hospital expense	Surgical expense	Regular medical expense
1962	60, 566	51, 769	48, 093	6, 993	8, 241	8, 343
1961	58, 797	50, 120	46, 190	5, 675	6, 803	7, 007
1960	58, 050	50, 281	45, 017	5, 542	6, 573	6, 773
1959	56, 825	48, 843	42, 999	4, 861	5, 813	6, 347
1958	55, 205	46, 424	38, 860	4, 865	5, 572	6, 015
1957	54, 923	45, 383	36, 926	4, 947	5, 597	6, 019
1956	53, 162	42, 570	33, 907	4, 654	4, 909	5, 276
1955	50, 726	39, 165	29, 451	4, 530	4, 340	4, 639
1954	47, 484	34, 899	24, 668	5, 196	4, 801	4, 908
1953	45, 727	31, 415	21, 578	5, 248	5, 298	5, 432
1952	43, 475	27, 773	18, 321	5, 367	4, 794	5, 150
1951	40, 933	24, 095	14, 347	3, 531	2, 790	2, 791
1950	38, 822	19, 690	11, 428	3, 619	2, 919	2, 873
1949	34, 315	14, 628	8, 508	3, 760	3, 820	3, 835
1948	31, 246	10, 608	5, 712	3, 765	3, 824	3, 839
1947	27, 986	7, 080	2, 985	3, 775	3, 829	3, 844

[1] Adjustment makes allowance for duplicate coverage under individual and group policies issued by commercial carriers.

[2] Includes persons covered by all policies written by special hospital insurance companies.

SOURCE: Annual surveys, "The Extent of Voluntary Health Insurance" or its predecessor published by the Health Insurance Council.

must be shifted in some fashion to the younger generation. This can be accomplished within the framework of a purely voluntary insurance system only if the younger insured persons can reasonably expect that a similar cost transfer will be made for their benefit when they move into the higher age brackets. As a result, this kind of financing is probably subject to severe practical limitations on the scope of the coverage of the aged supplied by such cost transfers (*14d*).

The two most widely advocated methods for providing adequate health care services for the aged consequently are (*a*) retention of a further improved voluntary system coupled with an expanded and liberalized public assistance program or (*b*) incorporation of health care benefits for the aged into the existing social security system. Whichever method will ultimately be chosen is bound to produce numerous novel technical legal questions.

On the other hand, it cannot be expected that the present system of voluntary prepaid health care plans will be totally superseded in the near future and, therefore, existing legal problems will remain with us for a considerable time. As a result, a tentative catalog of the chief legal and legislative problems within the present framework of health care organization is offered.

The ban against corporate practice of medicine. Although the old obstacles against organized health care plans, built upon that proscription, have been torn down, the rule has gained new life in barring hospitals from employing certain medical specialists, such as

Table 5. Benefit payments, 1952–62 (millions of dollars)

Year	Hospital			Surgical and medical		
	Blue Cross-Blue Shield	Commercial insurers	Independent plans	Blue Cross-Blue Shield	Commercial insurers	Independent plans
1962	$2,081	$1,899	$178	$820	$958	$235
1961	1,868	1,686	171	737	854	226
1960	1,647	1,477	126	671	753	175
1959	1,458	1,319	112	604	683	152
1958	1,303	1,186	100	531	623	140
1957	1,159	1,080	90	478	575	125
1956	1,010	900	80	405	465	85
1955	870	745	75	330	445	65
1954	745	615	85	300	375	60
1953	650	540	85	270	325	60
1952	561	437	74	221	261	55

Table 6. Private financing of medical care, 1953–62

Year	Medical care (net total in millions)[1]	Percent met by insurance[2]	Hospital care (millions)	Percent met by insurance	Physicians' services (millions)	Percent met by insurance
1953	$10,547	18.2	$2,909	44.2	$5,972	32.1
1954	11,318	19.3	3,167	45.5	6,503	33.5
1955	12,292	20.6	3,512	47.8	6,945	36.5
1956	13,670	22.1	3,827	52.8	7,614	39.6
1957	14,848	23.4	4,137	55.7	8,238	42.2
1958	16,032	24.2	4,432	58.5	8,985	43.1
1959	17,503	25.1	4,746	62.1	9,847	44.7
1960	18,803	26.6	5,207	64.5	10,595	47.2
1961	19,771	28.8	5,667	67.8	11,244	50.6
1962	20,885	31.1	6,098	72.1	11,721	54.6

[1] Includes hospital care, physicians' and dentists' services, drugs, eyeglasses and appliances, nurses' services, and nursing home care; excludes insurance net costs.
[2] Allocation made pursuant to estimates of Health Insurance Association.

radiologists and pathologists, on a salaried basis (*38*, *39*). It is doubtful whether such prohibition is still in consonance with modern developments in diagnostic and curative techniques. The hospital or clinic has moved into the center of the supply of medical care. The public expects this type of service to be available there, and some courts have held that such expectation is backed by a legal sanction. Thus in *Garfield Memorial Hospital* v. *Marshall* (*40*), it was held that plaintiff, entering a hospital for the purpose of a delivery expected to have complications, was entitled to "have the services of a doctor, when required, during the absence of her private physician and until he can respond to the hospital's summons." In a similar vein in *Treptau* v. *Behrens Spa* (*41*), the court concluded that the rule barring a hospital from lawfully engaging in the practice of medicine does not immunize it from liability for malpractice committed by a physician employed by the hospital to provide proper treatment to its patients.

True, some States have relaxed the rule for nonprofit operations. The California Business and Professions Code (*7*), for instance, provides that the Board of Medical Examiners may "grant approval of the employment of physicians and surgeons on a salary basis by licensed charitable and eleemosynary institutions, foundations or clinics or by approved medical schools operating clinics therewith, if no charge for professional services rendered patients is made by any such institution, foundation, clinic or school." It is, however, a question whether such liberalization goes far enough and whether it not unduly rigidifies the proscription vis-a-vis other hospitals. Certainly, Willcox's plea (*38*) for a more discriminating approach to the problem deserves serious consideration on the judicial as well as the legislative level.

The desirability of legal standards for coverage provisions and rating techniques of prepaid health service plans. At present, State laws vary greatly with respect to the regulation and supervision of prepaid hospital and medical care arrangements. In California, for instance, hospital and medical care insurance written by commercial insurance carriers is subject to supervision by the Insurance Commissioner (*42*); thus the same is true with respect to nonprofit hospital service plans (*42a*), while nonprofit medical service corporations, whether established as general nonprofit corporations or nonprofit professional service corporations (*43*), are exempted from such control. In New York, conversely, nonprofit medical and dental expense indemnity corporations, as well as hospital service corporations and commercial insurance corporations, are subject to supervision by the Superintendent of Insurance (*44*). Turning to the prescribed standards, it may be mentioned that in California legislation has been enacted prohibiting fraudulent and deceptive practices or coverage "not sufficient to be of real economic value to the insured" (*45*). Such legislation may regulate the format of the policies or certificates as well as their content. Special legislative attention has been given in New York to provision of compulsory renewal and conversion rights in connection with individual or group contracts for medical or hospital expenses (*46*). Control by the insurance commissioner over medical and hospital service

Table 7. Expenditures under public medical care programs, 1959–62 (in millions)

Program	1959–60	1960–61	1961–62	1962–63
Workmen's compensation (medical benefits only)	415. 0	445. 0	470. 0	500. 0
State temporary disability insurance (medical benefits only)	40. 2	43. 8	45. 5	50. 0
General hospital and medical care	1, 952. 2	2, 202. 8	2, 140. 3	2, 242. 1
U.S. Defense Department facilities	815. 7	848. 6	923. 9	911. 3
Medicare	60. 0	60. 8	71. 4	73. 0
Public assistance (vendor medical payments)	492. 7	588. 9	812. 4	1, 008. 5
Medical rehabilitation	17. 7	20. 4	22. 5	25. 5
Veterans' hospital and medical care	869. 5	935. 1	940. 9	996. 2
Maternal and child health services	138. 8	151. 8	173. 3	185. 4
Total	4, 801. 7	5, 297. 2	5, 600. 2	5, 992. 0

SOURCE: Based on reference *34a*.

plans may extend to the rates charged. Thus, New York requires that the rates not be excessive, inadequate, or unfairly discriminatory (*47*). Supervision of this type opens the troublesome question of whether community rating or experience rating should be the norm. This question has been discussed by MacIntyre (*35*).

Certainly the great variety in State responses to the problem of control demonstrates the need for further research in this area.

Resolution of multiple coverage problems. Another important area of needed further study concerns the problems arising from multiple coverage. Because of modern industrial conditions, it is not impossible that a worker receiving medical treatment may be covered by workmen's compensation, a group insurance policy, and an individual contract. Which organization shall bear the ultimate financial responsibility? Unraveling tangles like that in the proper fashion is not an easy task and presents a thorny policy issue.

Obviously other kinds of problems could be added. The organization for providing health services is in the stage of a fundamental reorientation. The law must be a pathfinder and guardian in that process.

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