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**THE STAKE OF MINORITIES IN NATIONAL
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THE STAKE OF MINORITIES IN NATIONAL HEALTH LEGISLATION*

NEEDS AND PROPOSALS

The necessity of comprehensive provisions for the care of the health of the American people has long been obvious. The war threw into dramatic focus the vital value of health to the efficient functioning of a nation, and at the same time the unsatisfactory condition of health in the United States, as reflected in the results of the Selective Service examinations. Experience has indicated that national legislation will be necessary for the attainment of desirable standards of medical care on a nation-wide basis. Such legislation must be directed toward numerous specific objectives and has been in process of enactment for a number of years. We are familiar with national measures to provide for sanitation, for control of particular diseases like tuberculosis and venereal infections, for research in cancer and for care of the mentally ill. The most recent legislation has been directed at assuring proper individual care for all the people. Two measures with this objective are: (1) the Hospital Survey and Construction Act (Hill-Burton Act), signed by President Truman on August 13, 1946; and (2) the National Health Bill (Wagner-Murray-Dingell Bill), S. 1606 of the 79th Congress. The former has the purpose of placing adequate hospital and health facilities, developed according to overall coordinated planning, within reach of every individual in the nation. The latter provides for the extension of existing public health services and for health insurance affording complete coverage of medical services and hospitalization for every citizen irrespective of economic

status. These measures have excited great public interest and except for the provision of national health insurance, all the proposals have received general approval from lay and professional organizations alike. The health insurance or "personal service benefits" section of the National Health Bill has aroused violent controversy. Endorsed by welfare and religious groups, official government agencies, and labor, it has been vigorously opposed by the American Medical Association. The National Medical Association, representing Negro physicians, has endorsed the bill with certain suggestions for amendments.

All persons of limited financial resources have an enormous stake in this legislation. In 1939, when living costs were much lower than they are today, an analysis by the American Medical Association showed that families earning up to \$3000 a year were unable to meet without assistance the costs of major sickness. It has been estimated that this category would include approximately ninety-eight per cent of the Negro population.

The minority concern with legislation for the protection of health exceeds the scope of these bills, however, and extends to matters of professional education and personnel.

The proper care of the health of a great population requires: first, scientific knowledge; second, professional personnel; third, materials and facilities; and fourth, practical arrangements for making these resources available when and where they are needed.

A century ago we were sadly lacking in all four of these categories. Today it is the latter two and particularly the last, in which we are most deficient. It is true that major gaps still exist in our knowledge,

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(witness cancer, infantile paralysis and the common cold), but the identification of the causes and processes of diseases and the development of effective treatments of programs of control have advanced so far that even with our unequal distribution of medical care and economic security, the average life expectation of an American was extended in the first four decades of this century, from 49.7 years to 65.1 years, an increase of fifteen and a half years.

All population groups, however, have not shared equally in the total health improvement reflected by this increased longevity. Negro life expectation at birth is about ten years less than that of whites. In 1940 life expectancy for males was 52.26 years for Negroes and 62.81 years for whites, and for females, 55.26 years for Negroes and 67.29 years for whites. This lag of Negro life expectancy about ten years short of that of the white indicates that the Negro participates less rapidly and fully in scientific and economic benefits which tend to prolong the life span, since in modern society shorter average duration of life is almost invariably correlated with the adverse conditions imposed by low economic status. Mass survival to old age is distinctly a recent human achievement. The shorter life of the poorly circumstanced means that for them the hazards of life are comparable to those of primitive and medieval times.

PROFESSIONAL PERSONNEL

In 1940 there was one physician for every 750 persons in the United States. The accepted minimum ratio for public safety is one physician to every 1500 of population. The ratio of one to 750 has existed in this country since 1910, indicating that during the intervening period the increase in number of physicians has remained proportional to population growth.

Here again, however, a differential is

found between the national average and that of the nation's largest minority and an even more striking association between concentration of physicians and the wealth of a locality.

In 1942 the number of Negro physicians in the United States was estimated at 3810, a proportion of one to 3377 Negroes. The range by states was from one to 1002 in Missouri to one to 18,527 in Mississippi. But two cities in the country, Washington, D. C., and St. Louis, Missouri, had a proportion approximating the national average of one to 750. These data indicate the degree to which the Negro minority has lacked adequate professional personnel for its needs.

Physicians tend to concentrate in areas of high per capita income. In 1923 the physician population-ratio for the most urban states was one to 651, as compared with one to 1042 for the most rural states. By 1938 the ratio had changed to one to 585 for the most urban and one to 1250 for the most rural states. In 1938 in the counties of the United States with highest per capita income, the physician-population ratio for physicians of all ages was nearly four times as great as in the poorest counties, while for physicians under forty-five years of age the ratio was eight times larger.

An additional factor, which renders areas attractive to physicians, is the availability of hospital facilities. In 1938 there were only sixty-seven physicians per 100,000 population in counties without general or allied special hospitals as contrasted with 157 in counties with 250 or more beds. Irrespective of income class, the ratio of physicians under forty-five years to population is twice as high where hospital beds are numerous. Again the wealthier urban states have the larger number and better quality of hospital facilities because of their greater ability to finance them.

MATERIALS AND FACILITIES

Our resources and production of medicinals and medical equipment are unrivalled in the world. The American public, however, spends enormous sums inadvisedly for these in the form of patent medicines and apparatus for which there is little or no sound therapeutic basis. Conditions today are greatly improved over the past due to the pure food and drug laws and other measures of control. Drug store prescribing is still much too frequent a resort of the indigent.

The extensive hearings on the recently enacted Hospital Survey and Construction Bill, conducted by the Senate Committee on Education and Labor, revealed great needs for hospitals and health facilities. The Committee accepted as standards of adequate facilities the following ratios: 4.5 general hospital beds per thousand of population, 2.5 tuberculosis beds per average annual deaths from this cause, five beds for mental and nervous diseases per thousand of population, and one health center for every 30,000 of population. In its latest official estimates the United States Public Health Service reported current needs exclusive of Federal health facilities as follows:

Type	New Beds (Deficit)	Replacements
General hospitals	169,579	83,889
Tuberculosis hospitals	65,189	17,313
Mental hospitals	208,963	99,583
Hospitals for chronic diseases	270,173
Total	713,904	200,785

The total cost of providing 714,000 new beds, 201,000 replacements and 4500 new public health centers has been estimated at \$3,939,000,000.

The Hospital Survey and Construction Act provides for \$1,125,000,000 of federal, state and local funds to be spent over a five-year period. This will meet less than a third of the nation's real hospital needs.

Of the total sum, only one third, or \$375,000,000, may come from federal funds which will be made available at the rate of \$75,000,000 a year for five years. States are entitled to allotments on the basis of per capita income. Two million federal dollars is immediately available to the states for planning. The entire hospital program will be under supervision of the Surgeon-General of the U. S. Public Health Service.

AVAILABILITY OF MEDICAL CARE

It is in the sphere of making medical services available that our greatest deficiencies exist. We have dealt with health as a purchasable commodity. Under our system the average citizen has been entitled to only such medical care as he could pay for. As a result those who have needed most in medical services have had least, and our best facilities and personnel have become concentrated in the urban centers of greatest wealth.

Various forms of voluntary prepayment insurance plans have been developed as a solution of limited application to the great and increasing costs of medical care. The best known of these are the Blue Cross plans for hospitalization. More than 21,000,000 people in forty-five states are participants in about eighty such plans. Blue Cross plans provide for hospital care and nothing else. There are a number of other medical care organizations which under various arrangements provide for medical services other than hospitalization and sometimes include the latter. Group Health Association of Washington, D. C., is an example of these. Dues in this organization are \$2.50 per month for each adult, and \$1.75 per month for each child, or \$10.25 per month for a family of five.

These voluntary plans are available only to individuals who can pay for them. For this reason their coverage is limited and the premiums relatively high. They can service only a small segment of the

population and cannot provide for the enormous numbers of the poorly-circumstanced who are in greatest need of medical services.

THE NATIONAL HEALTH BILL

The National Health Bill in its provisions for "Personal Service Benefits" affords for the first time a means of overcoming the economic barrier to health care. It provides complete coverage for everyone.¹ The current system of classification of individuals into indigent and "able-to-pay" groups is done away with.

Under the bill, all persons earning an income would be taxed a percentage (estimated at three per cent up to \$3600) which would provide the insurance fund. All citizens would have complete health coverage including professional and laboratory services and hospitalization. This is based on the soundest possible insurance principles. By including the entire earning population the smallest premium and lowest administrative costs are possible while, at the same time, maximum coverage is extended. There would be free choice of physician by patient, and physicians would be free to accept or reject patients as at present. Physician's compensation could be given in one of three ways: (a) on a fee for service basis; (b) on a capitation basis; (c) by salary. The method used in a given locality would be determined by majority vote of physicians in that locality. But a doctor wishing to be paid by another method would be permitted to do so. It would be expected that the fee for service would be the method most widely used in heavily populated urban centers. The capitation method would be useful in communities of fairly stable size and predictable morbidity. The salary method would provide for the first time a means of making physician's services available in rural and remote areas

¹Except railroad workers, who are already covered under another plan.

which could not possibly support a physician through local means.

We have seen that the Hospital Construction Act would provide means for erecting hospitals in such areas. The National Health Bill would provide means for paying the physicians who would staff them.

MINORITY HOPES AND FEARS

Under our system of government the question of state's rights arises on all issues affecting the whole people. In the past these difficulties were often regarded as insuperable. For example, it was at first necessary for a motorist to have on his car a license plate for each state through which he drove and it was no uncommon sight to see automobiles with tags of two, three and four states. Today, the absurdities of that situation have been eliminated and a motorist may drive throughout the forty-eight states with one license plate.

At the present time there is strict provision, both in the Hospital Construction Act and the National Health Bill, that while the top administration, supervision and review would be in federal hands, the local implementation of the legislation would be through state and local officials. Though minorities rejoice in the objectives and practical provisions of both these epochal measures, they fear that existing practices in many states, particularly those in which the bi-racial system is traditional, will result in discrimination against them; that efforts to perpetuate the entrenched social system there will mean delay in their enjoyment of the benefits provided by the measures and possibly in their case actual failure of the objectives of the bill altogether. Attempts to provide separate "but equal" facilities have never proved successful in the past and it is not believed that success could be possible in the case of the present health measures. In short, minorities are afraid

that the same obstacles which have prevented them from getting a square deal in the past might obtain in the case of this legislation.

The months ahead will be critical in respect to these matters. In the National Health Bill there is provision for advisory boards of both national and local character. Minorities should be deeply concerned in having effective representation effectively placed on these boards. The training programs provided for under the bill would have great size and scope. Members of minority groups would consider it vital to be included at all levels, administrative as well as professional, in this program and they would be deeply apprehensive of any suggestions to establish for them separate institutions, separate programs or separate systems of administration.

Minorities have witnessed many circumstances and sometimes defiance of the law in respect to various Supreme Court decisions. Some doubt has already been expressed as to whether a national law could be more successful in respect to health care than it has been in respect to education, inter-state travel and the rights of franchise.

These misgivings, however, have not deterred the nation's largest minority, which consists of its fourteen million American Negro citizens, from giving unqualified endorsement to the National Health Bill. The National Association for the Advancement of Colored People, the largest and most representative organization of Negroes; the National Medical Association; the National Dental Association, representing colored physicians and dentists as a whole; and the Medico-Chirurgical Society of the District of Co-

lumbia, which is the oldest Negro medical organization and the largest local society of the group, have all endorsed the National Health Bill. They see clearly that this legislation would finally provide the bridge so long sought across the economic barrier between medical services and the people who need them. It is their hope that no segment of the nation would be so blind in any attempt to preserve traditional social patterns as to withhold from the whole people benefits of the magnitude possible through the bill.

There can be no mistaking the intention of the Federal Government to raise the national health to the highest possible standard in every respect. Among the United Nations the United States has assumed a position of world leadership in health matters and it is most vital that our own house be set in order. Already we are behind many nations in providing for national health insurance.

The bill for a National Science Foundation, reintroduction of which has been promised in the next Congress (it was passed by the Senate during the last), also contains in its provisions for funds and programs for medical research and scholarships, items of deep significance for minorities, in that here also appear means for overcoming the retarding factor of economic limitation and even more important, for facilitating the impartial recognition and development of ability in whomever it occurs.

No citizens have greater stake than our minorities in the national health program now promulgated. No nation has fullest use of its resources in which any group of citizens does not enjoy good health or holds untapped reservoirs of human ability.