A History of Medical Payments:

Continuity or Crisis?

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Abstract

The form and amount of medical payments has been a contentious issue throughout the history of Western medicine. The prices charged by doctors, and the actual payments they receive, have reflected a complex interaction of the social, economic, and political forces impinging upon medical practice. Contemporary concerns about the medical payment system in the U.S. relate, in part, to the unprecedented scale and complexity of the modern system of medical payments. Historical analysis reminds us that medicine and money have always made odd bedfellows. Today's problems may seem intractable, but such problems have been consistent throughout medical history.

Key Words: History of medicine, payment, fees, elite, the poor, direct payments, regulation, Benjamin Rush, competition.

IN THE HISTORY OF WESTERN MEDICINE, very few things have remained constant through the ages. Among the few universals one might point to is the following: doctors have always expected to be compensated for their services, just as patients have expected to pay for the care of a doctor. While generalizations across time and culture are often of little value, this consistency in medicine stands in rather striking contrast to the well-documented changes that have occurred in the theory and practice of healing in the West, in the social roles of doctors and other healers, and in the institutional and economic context in which medicine has been practiced. An equally striking fact that one can deduce from such a broad historical sweep is that medical payments have frequently been an issue for doctors and their societies. Such payments have been an issue both for the manner and size of compensation and for their impact on the way in which doctors and patients have related to one another.

Before beginning a consideration of the history of medical payments, we might pause to consider the various types of medical payment that have existed throughout time. These include payments from patients to doctors for a consultation, diagnosis, and recommendations for treatment; payments from patients to doctors, or to others, for medical preparations to treat specific ailments; payments from various corporate bodies such as a city, or from an individual such as a ruler, to a healer as a retainer; payments from doctors to patients as compensation for failed or negligent treatment; payments from individuals seeking medical education; payments to corporate bodies such as hospitals for services; payments to bodies acting as pools of risk for individuals against future medical catastrophes; or lump sum capitation payments from such corporate bodies to individuals or groups of doctors for treating given populations of patients. Each of these forms of payment, further, can involve various third parties, such as insurance companies, fraternal organizations or government agencies. So the problem we face in trying to understand the history of these systems of payment is rather daunting. For the purposes of my discussion, I will focus only on

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the simplest case—direct payments for medical services.

Elite Medicine and Service to the Poor

Of course, this discussion is already skewed somewhat by use of the word “doctor.” By using this term we call to mind healers who are part of an elite, and in some form, exclusive medical tradition rather than part of the historically ubiquitous medical panoply of others who offer a variety of services to those in need of healing. If we exclude these lay healers—who more often than not are willing to offer services at a price that meets the market—we can then focus on those for whom the question of medical payments, and the social perception of those payments, is most acute. These elite practitioners (I will henceforth simply call them “doctors”) have tended to be particularly cognizant of these issues. Medical writing is full of doctors encouraging their professional colleagues to think about both the manner in which they charge their patients and about how these charges, and the lifestyles they lead to will be perceived among the wider public.

So doctors face a fundamental economic and social dilemma. Since illness strikes rich and poor alike, doctors must necessarily provide services to a wide range of people from varied social and economic positions. Yet doctors, as highly trained specialists with what they perceive to be special knowledge and unique powers, also feel a professional separation from the mass of society. In this way, physicians have to some degree always wanted to be seen, and see themselves, as removed from the great mass of society. This elitism has had both a social and economic dimension to it. In the ancient world, the Greeks were fond of a quotation from Homer that seemed to secure the place of the doctor above others in society. In *The Iliad* (1), when the physician Machaon is wounded in battle he is quickly removed from danger, for “a doctor is worth many men put together, at extracting arrows and applying soothing ointments.” Historian Vivian Nutton notes (2) that the Greeks tended to omit the second and more practical half of this couplet, in such a way as to confirm “the doctor’s own self-image as a man somehow raised above the majority by his skills.” Such a belief, of course, plays somewhat on the dual meaning of the word “worth” in Homer’s verse, with its economic as well as social connotations of value. A doctor who is of greater value to society than others can presumably leverage that greater worth into fees commensurate with his social utility.

The degree to which ancient physicians such as Hippocrates set themselves off from society in general and from those of a lower social class in particular is controversial. Little can be said with certainty about the life of that most famous ancient doctor, other than the starkly economic fact that he was willing to teach medicine to anyone who could pay (3). This is particularly ironic in light of the Hippocratic Oath’s admonition to teach the healing practice for free, but only to those within the Hippocratic extended family. While we need not be surprised by such tensions in the Hippocratic tradition, which are well known, this particularly sharp contradiction should serve to remind us just how thorny issues of money can be in medical practice.

An especially sensitive issue, not surprisingly, has tended to be the gap between the relative affluence of elite doctors and the financial resources of their patients. While this problem has not been historically universal, since at times even elite doctors have been placed in economically challenging circumstances, it has persisted. Particularly troubling has been the charge that doctors have ignored, or been unwilling to treat, those who are unable to pay their fees. Hebrew doctor Asef Judaeus wrote in the eighth century that the physician should be wary of failing to provide services for the poor (4): “Do not close thy heart to mercy toward the poor and needy,” he wrote in his *Admonition*. Judaeus also composed an entire treatise on the treatment of the poor, comprised of remedies that could be procured for nothing. He also had his students swear an oath that bound them to attend to the poor without charge (5). Closer at hand, early American doctor Benjamin Rush was more forthright in his insistence on the treatment of the indigent and on the related topic of the social perception of doctors’ fees and their lifestyle. In *The Virtues and Vices of Physicians* (6), he noted with chagrin that “[a]varice in all its forms of meanness, oppression, and cruelty is a frequent vice among physicians.” Rush had in mind, no doubt, the denial of services to the poor, but also shows of ostentatious wealth by doctors.

This issue of doctors’ treatment of the poor was a particularly sensitive one for Rush. With a practicality reminiscent of his contemporary Philadelphian Benjamin Franklin, he noted that physicians do a particular disservice to them-

selves and their profession when they deny service to older patients who have fallen on hard times, particularly those who they treated in the past. Such "sordid conduct," Rush asserted, was particularly heinous, since these patients had often been the ones who had first patronized a physician's services and to whom the doctor was therefore in debt for his success. The late-nineteenth-century medical crusader Elizabeth Blackwell was more absolute on this issue (7), noting that physicians must not "enter upon medicine as a trade for getting money." For Blackwell this issue was in many ways at the very heart of medical practice (8), since it was her firm belief that "every branch of medicine involves moral considerations, both as regards the practitioner and the patient. Even the amputation of a limb, the care of a case of fever, the birth of a child, all contain a moral element ... which cannot be neglected without injury to the doctor, the patient, and to society." For Blackwell to extend these moral considerations to money was particularly significant, since it was for her a basic reason why women needed to enter into the medical profession as reformers and moral guardians. Critiquing medicine as too much of a business was one way that Blackwell proposed moving medicine back to what she believed were its true roots: the care and ennobling of humanity. Blackwell's sense was that this represented a job for which women were particularly suited.

Government Regulation of the Medical Marketplace

Given the economic issues related to medical practice and the power that doctors have over their patients' life and death, it is not surprising that this aspect of medicine has often been the target of government control or regulation. Like so much else in medicine, medical payments have often, though by no means universally, been legally regulated. A striking example of this comes in one of the world's most ancient law codes, *The Code of Hammurabi*, which was used to govern the ancient civilization of the Babylonians nearly four thousand years ago. *The Code* contains a number of regulations concerning the rights of doctors to receive specific payments for services they provide, and what could best be described as malpractice protection for patients against failed operations. Significantly, specific payments are set for particular procedures, perhaps the first recorded instance of medical price fixing. Thus, code number 215 requires that "if a physician make[s] a large incision with an operating knife and cure[s] it, or if he open[s] a tumor (over the eye) with an operating knife, and saves the eye, he shall receive ten shekels in money." Correspondingly smaller payments, one-half and one-fifth the above amounts respectively, are required for successfully performing the same procedures on plebeians or on slaves. Similarly, payments for the curing of a disease in "the soft part" of a man or the setting of a broken bone brought payments of five, three, and two shekels for patients of the upper, lower, and slave classes respectively. On the other hand, failed surgeries brought serious consequences for the physician. If an upper class patient died after surgery, or lost an eye in a failed ocular procedure, the physician lost the hand that had done the cutting. Similar failures on lower class or slave patients brought less catastrophic consequences for the doctor: the death of a slave was compensated with the full value of the slave, the loss of a slave's eye imposed on the physician half of the slave's value (8). While such regulations might seem draconian by our standards, they did serve to protect to some degree the interests of doctors as well as patients. Those who entered into the role of healer had a clear sense of both the risks and rewards of their chosen field. Patients could count on a surgeon who had a real stake in their case's outcome, and the barrier to entry for quacks and other charlatans was dauntingly high.

At other times, the regulation of payments to doctors has been less overt. Many periods witnessed neither government oversight of medical practice nor regulation of the medical marketplace. But more often than not, the response of political authorities to the difficulties posed by medical payments lay somewhere in between complete control and total *laissez-faire*. The medieval period is an excellent example in this regard: healers were often kept under the watchful eye of both the secular and ecclesiastical authorities in many areas throughout this period. This was particularly true in the High Middle Ages. During this era the Church moved aggressively to bar members of monastic orders from the practice of medicine, largely because of its economic profitability. The Church's regulations, designed to discourage "temporal gain" among the members of the mendicant sects, demonstrate the degree to which the profit motive underlay practice even in that era (9). Similarly, the medical guilds of the late medieval era had a strongly economic

foundation, although they also served as bodies regulating practice and licensure, as well as ensuring competence. By limiting medical practice, though, to those who had their imprimatur, they provided the underpinning for a regulated price structure as well. Of course, these guilds were formed and run by the practitioners themselves, and so were not official governmental bodies. But like all medieval guilds, they were enmeshed in the larger feudal system, their charters generally granted by local authorities, and they were thus ultimately not independent organizations but rather subservient to the local sovereign.

Medical Payments in the U.S. Before the 20th Century

This historical survey of medical payments is not meant to be comprehensive, but rather to provide some perspective on the issue that we are most concerned with, namely the development of the modern American system of medical payments. Medicine in the U.S. has gone through its own peculiar historical development. It began, as typified by the aforementioned early American doctor, Benjamin Rush, as an outgrowth of the medical world of Europe in the early modern period. Like many doctors in the late colonial and early national period, Rush was educated both in the New World and in the Old. He earned his M.D. from the University of Edinburgh in 1768 and helped to establish the first American medical school in Philadelphia soon after. In his autobiography, Rush commented extensively on the development of his practice as a business enterprise. He noted that when he began his practice, he had few of the advantages that would have secured an easy entry into a successful practice in urban and relatively wealthy late-eighteenth-century Philadelphia. These advantages included (10) “the patronage of great men,” the “influence of extensive and powerful family connections,” and “the influence of a religious sect or political party.” Hence, somewhat ironically, Rush concluded that the only means at his disposal for the securing of business was to attend to the medical needs of the poor.

For support in this venture, Rush had several pearls of wisdom. First, he recalled having once read as a boy an autobiography by famed Dutch physician Dr. Hermann Boerhaave, whom he remembered as saying (10) “the poor were his best patients, because God was their paymaster.” By this, one can only assume that Boerhaave, and his disciple Rush, saw their reward for medical services to the poor to be part of their spiritual redemption. The other bit of advice was knowledge he had of two other physicians, one in Scotland and the other in England, who had established themselves in the same way. Rush, never one to downplay his own achievements, also noted that attending the poor was in line with his own natural sympathies, which was to react with kindness to every person in distress. For the first several years of his practice, much of his business seems to have been made up of such patients. Rush found success in this path; his business and professional standing were gradually built up over the course of his first decade in Philadelphia, although not without arousing some antipathy among the established doctors of the region. Others apparently objected both to the way that he carried on his practice and to the medical ideas that guided him. Nonetheless, within about five years his practice had grown from almost nothing to an annual income of £900, Pennsylvania currency. While the value of colonial currency was notoriously fluid, this might translate into about £500 sterling, which was certainly a comfortable living in the late eighteenth century.

Rush also provided a kind of summary of the business aspects of his practice during his more than thirty years of work. Overall, Rush estimated that he had never been compensated in any way for approximately twenty percent of his business, either due to explicitly providing services free of charge to the poor or though the nonpayment of bills. Despite the large percentage of service provided without charge for one reason or another, Rush felt little remorse for this unpaid work. Indeed, he emphasized that whenever patients asked for their bills to be reduced or forgiven, he did so without hesitation. And he was proud of the fact that he had provided medical services at no charge to the colonial forces in the Revolutionary War. His one regret was for not being more aggressive in pursuing those who had failed to pay despite being in a financial position to do so. His sorrow was not so much for his lost income, as his feeling of having encouraged such people to ignore their social obligations, and thereby having allowed such individuals to defraud others (10).

Rush’s experiences represent those of a successful, and ultimately prominent, urban physician in the late-colonial and early national period. The experience of American doctors in other settings, though, was not as rosy. For

those who practiced medicine among the urban poor, or on the less densely populated frontier, the physician's life and business practice could be much less rewarding. One nineteenth-century American doctor, James B. Cranfill, reported the following after beginning his practice in the state of Texas in 1879 (11): "I was enabled to collect the first year of my practice $1500 [sic] either in money or convertible trade. I was not a stickler for details in the matter of collections. I would take anything on a medical bill from watermelons to cord wood, from cabbages to calves. I soon had an assortment of property, and was able, by my natural trading instincts, to make good use of it." Medical practice on the frontier often necessitated such creative business dealings. Currency was scarce, and the trade in precious metals was uncertain at best. Around the same time, in 1877, Dr. Henry F. Hoyt had an unfortunate encounter with one of his first patients, after literally hanging out his shingle in the town of Deadwood in the Dakota Territory. Two years before, gold had been discovered in the Black Hills, bringing thousands of prospectors, and one novice and somewhat naive physician, into the region. Hoyt was quickly taught a lesson in frontier medicine. After traveling ten miles outside of town to see one of his first patients, who had a serious gunshot wound, Hoyt was paid with a considerable pile of gold dust. Upon his return to town, however, he was shocked to be told by that "a good part of [the] dust was phony." Hoyt learned his lesson, though, and henceforth carried with him in his medical saddlebag a bottle of acid to test the validity of his fees (12).

Under these conditions, many doctors in frontier regions attempted to contract out their services in advance. This strategy, when it could be put into effect, had many advantages, chief of which was that the physician could demand prepayment. They also frequently supplemented their income by supplying customers with various medications, generally their own concoctions (13). The difficulties faced by physicians in the business side of their practice were increased by the fact that, during this period, competition among doctors was expected. Such competition came not only from other professionally trained doctors but from an array of "healers" as well. In an era of Social Darwinism, the attitude that unbridled competition was a guarantee that the able would survive and prosper was widespread even among doctors (14). Such competition took its toll on doctors and their wallets. Around the turn of the century, a survey of the incomes of 46,000 doctors revealed that more than one-third earned less than $2,000 per year, and more than half earned less than $3,000. This would have placed the majority of them in the lower-middle to middle classes of society. During this period, however, the average income of the top one percent of doctors was $45,000 (15).

Such extremes in the medical business largely began to level off by the early twentieth century. Thanks in part to restrictions on medical education in the wake of the Flexner Report (16), the business climate for medicine began to change quite dramatically. Still, physicians and physician interests groups like the AMA continued to oppose those they perceived as having a detrimental effect on the business side of medicine. They were openly hostile to a variety of alternative medical practices, such as osteopathy and chiropractic, and to many innovations in systems of medical payments, including group practice and various forms of health insurance (14). By the 1930s, doctors had, for the most part, succeeded in stabilizing the economic conditions they faced by limiting the supply of physicians and convincingly setting themselves apart from other types of healers; this stabilization of the medical market, not surprisingly, came at a price to others. By the early years of the depression, concern had begun to arise about the increasingly high cost of medical care, the poor state of public health regulations and staffing, and the relative scarcity of professional physicians in rural areas. In 1927 a committee chaired by Dr. Ray Lyman Wilbur, with the support of the AMA, commenced work on the problem of the cost of medical care in the United States, with the goal of ensuring that "adequate medical services are to be made available at reasonable costs, to the citizens of this country ten or twenty years hence." While this group made a series of recommendations, their effectiveness at stemming the increasing problems in medical economics was limited (17). The perception of a crisis in medical payments, especially among the poor and in rural areas, continued to increase.

In Cooperstown, New York, a conference convened in the late 1930s to address the growing crisis in rural medical care. Of all the problems faced in the health care situation in rural communities, perhaps the most severe was the lack of doctors, caused in large measure by the extremely poor economic climate faced by rural doctors. At this conference, Lloyd C. Warren,

then president of the Otego County Medical Association, spoke about the severe problems encountered by rural doctors. According to his description, rural doctors faced real economic hardship. On the one hand, their fees were necessarily low, since the communities they served were generally fairly poor. On the other hand, they faced considerable expense. They needed to provide their own drugs and supplies, an office from which to practice, and a car, since house calls were common, especially for emergencies. In addition, conscientious doctors would incur expenses for medical journals, books, and professional dues. All of this meant that some 35 – 40% of a country doctor's gross income was consumed by these various expenses. On top of this, a country doctor's work was really a 24-hour job, since there was no one else to call when medical crises arose (18).

Conclusion

These narratives concerning medical payments in the United States and elsewhere suggest a few consistent, if not universal, tendencies in the way in which the business of medicine has been conducted. First, not surprisingly, it should be clear that the issues that we face now are not unique. Indeed, any perception that we are currently experiencing an unprecedented crisis in medical economics may well be exaggerated. The practice of medicine and the pursuit of profit have always fit together awkwardly, and in many ways the two simply do not work together. Second, as is often the case, the perception that problems that we face today are unprecedented, or particularly severe, does not bear out under historical scrutiny. This is not to deny, of course, that some of the issues that we currently face, such as the sale of organs or cost-saving incentives limiting services to patients, or indeed the scale of today's problems, are different from those in the past. The underlying issues, though, remain largely the same. How can medicine overcome the fundamental gap between the universal need for medical care in a world composed largely of people with limited means, and the need of doctors to be fairly compensated for their skills, time, and years of training? This dilemma may well be fundamental to medicine, and in an era when medicine has become among the biggest of businesses, the difficulties it raises loom larger than ever.

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