Chapter 18

Health Care Access

The need for better health care access has been a concern of the Health Department for many years. Dr. Charles Hewitt and Dr. Bracken, early executive officers of the Board of Health, and other early public health leaders advocated for services to reach all members of the population, especially the poor, the old, the sick.

In 1949, at a meeting of public health workers in Winona, Minnesota, agreement was reached that, "Not until everyone is able to benefit from medical science can a community be said to have adequate or ideal health services."[1454]

There had been a strong current of support for national health insurance in the early 1940s, but instead the federal government backed the Hill-Burton Act that provided funding for states to assist in constructing health facilities. Supporters of Hill-Burton thought this was a better way to address unmet health needs in the country. States could make their own decisions rather than letting the "Federal government to take over the entire medical care program of the United States."[1455]

While Dr. Albert Chesley, executive officer to the board; Dr. Robert Barr, deputy executive officer; Dr. Thomas Magath, board president and others wanted all Minnesotans to have access to health services, they didn't believe the proper route was through government-administered health insurance:

> Barr: "Last month I attended the Rural Health Conference. Dr. Chesley should have gone but didn't go. I haven't been able to learn why. The one thing that came out of it was that at the first conference one group, the Farmers Union, the most radical farm group, thought that everything should be socialized about medicine, and some of the medical groups and dental groups were pretty much the other way. That whole thinking is changed, and people in rural areas must have a doctor within 10 or 15 miles of them. They are trying to do everything to attract...a hospital within ten miles." [1456]

In 1950, the 18-month-old National Health Service Act in Great Britain was discussed. Dr. H. S. Diehl, dean of medical sciences and professor of public health at the University of Minnesota, said that the national medical system in Great Britain was adopted to meet an emergency. The conditions here were so entirely different from that of Great Britain as to make it pointless to discuss the possibility of a comparable health plan for the United States.[1457]

[1454] MDH, *Minnesota's Health,* Vol. III, No. 5, May 1949, p. 2.
[1455] Jack Bess, "If You Build It...," *American Hospital Association News,* July 20, 1998, p. 7.
[1456] BOH, *Minutes,* February 14, 1950, MHS, p. 29.
[1457] MDH, *Minnesota's Health,* Vol. IV, No. 3, March 1950, p. 3.

Any attempt by government or other organizations to control health care fees was met with strong resistance. The Southwestern Minnesota Medical Society and the Radiological Society challenged a program funded by the Kellogg Foundation because of proposed fee schedules the foundation set. Dr. Barr explained the resistance at the August 1, 1950, board meeting: "I think the point is that they attempted fee schedules which are approximately what we have in Minnesota at the present time. Somebody yelled, 'Socialized Medicine and Ewing,' and then the fat was in the fire. I am afraid that is going to happen time and time again."[1458]

The feeling of the time was voiced by Dr. J. D. Camp of Rochester at a special board meeting on June 13, 1950: "I think it would be a sorry day in medicine if the doctors permit government and public health to dictate to us the charges for examination."[1459] Board members were sensitive to appearing as if they supported a program similar to Great Britain's or appearing as though they supported socialized medicine. When reviewing a draft of the report of the review committee in 1954, one revision was made for the following reason: "I think the use of the word 'program' here is not good. Smacks of state medicine and if published in that way might make the Board suspect on this point."[1460]

The high cost of health services and the resultant access problems began to receive more and more attention during the 1960s and 1970s. Title 19 of the 1965 federal Social Security Amendments (Public Law 89-97) went into effect January 1, benefiting many of Minnesota's children and needy adults. Gov. Karl Rolvaag called this program a milestone in the state's efforts to help the needy. "Now, at least the factor of inadequate financial resources will no longer prevent these children from getting the...health care they deserve."[1461] While the program helped some children, others were still without access to health care services, primarily for economic reasons.

One of the early supporters of improved access to health care in Minnesota was state Sen. John Milton, head of the Senate Health Subcommittee. In 1973 he planned a three-day fact-finding trip through Clinton, Marshall, Worthington, Trimont, Albert Lea, Rushford, Winona and Plainview to get input from the population on the availability, quality and cost of health care in their communities.[1462]

Health Plan Regulatory Reform
Minnesota Health Care Commission.
Health Care Access Commission

Minnesota Care -- Because of the negative feeling toward "socialized medicine," it would have been very difficult for the heads of the agency in the 1950s to support a program such as Minnesota Care.
(Note: Additional coverage of health care reform is provided in Chapter 17.)

[1458] BOH, *Minutes,* August 1, 1950, MHS, p. 359.
[1459] BOH, *Minutes,* June 13, 1950, MHS, p. 287.
[1460] BOH, *Minutes,* May 11, 1954.
[1461] MDH, *Minnesota's Health,* Vol. 20, No. 4, April 1966, p. 1.
[1462] News release from the state Sen. John Milton, August 28, 1973.