living in provinces with low or no premiums, are protected through these plans as are the rest of Canadians. Thus, the great majority of the poor receive their care as part and parcel of so-called mainstream medical services. The two-class system of health care has been largely wiped out in Canada. At the same time, the hospital and medical care insurance plans have to date made only limited inroads on traditional medical practice.

The foregoing is in sharp contradistinction to developments in the United States, in spite of the fact that both countries are "capitalistic, pluralistic, competitive . . ." The present Administration's official health strategy, while emphasizing a move away from "categorical and piecemeal efforts", in fact proposes nothing of the kind. What is proposed is NHIP (National Health Insurance Partnership Act) for employer-employee groups, with major exclusions, deductibles, and coinsurance and out-of-pocket expenses, FHIP (Family Health Insurance Plan) for the poor and working poor, again with major exclusions, deductibles, limits on service, and out-of-pocket expenses. At the same time, Medicaid would continue for the poor, blind, and disabled, and Medicare for the aged. So we see four categorical assistance programs which, between them, would provide universal availability of coverage on a voluntary basis, with limited protection, rather than coverage of the entire population with broad protection. Major problems conducive to failure, proven repeatedly in the past, are built into this approach. When we note that as long ago as 1967 the Bureau of Labor Statistics estimated that a family of four required $9,191 to achieve a "moderate" way of life, how can we expect families with $4,500 or $5,000 annual income to pay the out-of-pocket expenses required by the proposed administration strategy? Income levels for a substantial minority of people will be low enough that premium subsidy schemes will produce another bureaucratic mess.

The foregoing needs to be placed in the context that probably between 40-50 million Americans are indigent or medically *indigent if any substantial health costs are incurred. At the same time, close to 30 million Americans are without any hospital insurance; half of all Americans have no protection against the costs of ambulatory x-ray or laboratory services; and more than half have no coverage for the costs of office or home visits to or by physicians. Clearly, in my opinion, the voluntary health insurance mechanism has failed in the United States. National health insurance has been the "lost reform".*[4]

What is the reality for the next few years? To a recent newcomer to the great and rich United States, it seems clear that a comprehensive system of national health insurance tied to fundamental reorganization of service is not in the offing. The much touted HMO strategy remains to be proven as a broad-based effort. After all the talk and all the years, prepaid groups protect no more than 5 per cent of Americans. After all the rhetoric, in 1971 the new comprehensive health center programs provided probably less than 1 per cent of the primary ambulatory services in the United States. Given all the foregoing realities, why then does the United States not make a start, as did Canada, by establishing a national hospital insurance and diagnostic services plan, to cover all Americans for inpatient, investigative and emergency services? At least that would be a small and relevant and realistic start on the road to health care as a right.

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Written for the Journal on invitation of the Editor, by Dr. Samuel Wolfe. Dr. Wolfe is Director, Comprehensive Health Programs, at Meharry Medical College, Nashville, where he also directs the Center for Health Care Research and is professor of family and community health. From 1962 to 1966, Dr. Wolfe was a Commissioner of the Saskatchewan Medical Care Insurance Commission, Canada's pioneer universal coverage medicare plan.

LETTERS to the editor

Smallpox Vaccination

I would like to raise my voice in order to join Dr. Blaney (Smallpox Vaccination, AJPH March, 1972—Letters to the editor) in protesting against the discontinuation of routine general smallpox vaccination in the United States.

I agree with Dr. Blaney in recommending that other health agencies do not adopt the PHS recommendation.

I would also like to bring up another point in the matter. It is the example that the U.S. Public Health Service can give to Public Health Service of the developing countries in Latin America.

Using the U.S. as a mirror, some "decision-makers" in the field of Public Health in Latin America are beginning to recommend the discontinuation of routine general smallpox vaccination.

If this idea could be a disaster in the United States, imagine it in the Latin America countries?

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Michael G. Davis

I noticed your editorial in the March 1972 issue of AJPH about the career of Michael Davis.

It brought back memories. When we developed the North End Clinic here, in the early 1920s (which was the starting outpatient clinic that later grew into the present Sinai Hospital of Detroit), we engaged him as our consultant.

I remember how cordial he was; always available for advice. His knowledge of health care problems was far in advance of the viewpoints of that era, as you describe. Much respect to you for digging up these memorabilia.

Harry C. Saltzstein, M.D., Editor, Bulletin, Sinai Hospital of Detroit.

1966 Revisited

As I review recent trends in our field I feel compelled to comment briefly on the rush of new legislative proposals and the effect they might have