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Propaganda

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SOME DEFECTS IN INSURANCE PROPAGANDA

European experience furnishes much guidance concerning difficulties to be avoided in sickness insurance and many suggestions as to details and technic, but it does not supply any guide as to whether similar systems will solve American medical problems. Thus far, sickness insurance has been almost exclusively a European system. Only Chile and Japan, in other continents, have followed the European example, and this to a limited degree. Australia, South Africa and certain provinces of Canada have had governmental commissions investigating the subject and have arrived at closely similar conclusions. All have approved the principle of sickness insurance, but legislation has not yet followed. All have favored the separation of cash and service benefits and the exclusion of lay insurance carriers from any part in the scheme. This has served to cool the ardor of many of those who have been most enthusiastic in urging sickness insurance.

In at least one respect the conditions in the United States at present differ from those which existed in any European country at the time sickness insurance was introduced. In no other country was there, prior to the beginning of sickness insurance, such a variety of extensive plans for care of the public health. In no other country during preinsurance days was there such a development of infant and maternity care, public health work, school health care and antituberculosis organizations as now exists in this country. This condition has been interpreted in exactly opposite ways. Some maintain that further expansion and better coordination of these various services will enable them to fulfil in the United States most of the desirable functions performed by insurance systems in other countries. Others claim that this widespread interest in health measures forecasts the introduction of some form of sickness insurance in the United States.

There is also the more fundamental question whether the attack on poverty in this country will take the European form of controlling the expenditure and supplementing the insufficiency of low incomes by public

philanthropy and subsidies to so-called insurance systems, or whether, instead, efforts will be made to increase the incomes of the low wage groups.

PREVIOUS AGITATION FOR INSURANCE

During the World War and the years immediately following there was extensive agitation for sickness insurance. At that time ten states appointed commissions to investigate this subject. No action followed any of these investigations. An analysis of the forces arrayed for and against such action may help to make it understandable why a movement that reached so great a size produced practically no results.

The advocates of insurance were drawn almost entirely from the ranks of philanthropists and social workers who represent, obviously, but a small voting force. Organized labor, for whose benefit sickness insurance appears to be largely designed, was indifferent or antagonistic. A few employers operating contract systems of medicine were favorable to sickness insurance. The large insurance companies were, for the most part, hostile. The medical profession was sharply critical. The politicians showed little interest. Consequently the movement collapsed, leaving little permanent impression.

Events of the intervening ten years have changed many features of the situation existing at the close of the War. There has been an extensive development of new forms of medical practice. Clinics have multiplied, hospitals have been greatly extended and laboratories have increased many fold. Many forms of contract practice, some of them pernicious, have developed and have grown in scope.

School health care, infant welfare and public health departments are other forms of medical service that have shown remarkable growth during the last decade.

Even more significant has been the steady expansion of workmen's compensation legislation, now operative in forty-four states and in all federal jurisdictions, with nearly \$80,000,000 paid annually for medical services. The system has, moreover, developed nearly all the good and bad features of the European systems of sickness insurance.¹

¹. *Medical Relations Under Workmen's Compensation*, Bureau of Medical Economics, American Medical Association, Chicago, 1933.

The advocates of sickness insurance hail all these developments as preparatory to a sickness insurance system. They alternately praise the accomplishments of existing health and medical care movements, criticize their insufficiency and demand their extension. The medical profession is not convinced of the efficacy of sickness insurance as a panacea; it is, however, studying the workings of all new institutions, seeking to remove their abuses, to increase their usefulness and to fit them into their proper place in a system of medical care.

COMMITTEE ON THE COSTS OF MEDICAL CARE

The present revival of interest in sickness insurance may be associated with the series of studies of the Committee on the Costs of Medical Care. The argument that dominates all these studies—apparently with the objective of the final endorsement of sickness insurance—is the claim that the irregular distribution of medical services, income and need for medical care make it impossible for a large percentage of the population to obtain necessary medical care. From this the conclusion is drawn that the only solution is a more or less forcible redistribution of income through a sickness insurance system.

There are so many defective links in this chain of facts and logic that the repeated conclusion is far from inevitable. It is not claimed by the medical profession that present methods of furnishing medical care to low income classes are perfect. It may be quite possible to develop plans that will alleviate some of the existing defects of such care and make it available to many who find it difficult or impossible to pay for all medical services out of present incomes.

These two premises, however, by no means lead to the conclusion that this country should immediately adopt a system of compulsory sickness insurance patterned after European models. Some of the points that throw doubt on the conclusion are: (1) the partiality and statistical inaccuracy of the data on present medical conditions; (2) the question of whether insurance will actually relieve the burden of sickness; (3) the absence of proof from the proponents of sickness insurance that other forms of attack on health and income problems will not produce more desirable

results with less cost, and (4) the question of whether a system can be developed that will not bring with it worse evils than those it cures. Practically all these points are evaded or ignored by the advocates of sickness insurance.

In the summary volume "The Costs of Medical Care," page 151, the statement is made that "for a large part of the population the problem of providing reasonably adequate medical care does not hinge on ability to pay a particular sum; it depends on (1) curtailment of wasteful expenditures, (2) efficient organization for the provision of medical care, and (3) the development of means of paying on a budgeted and anticipated basis." In other words, it depends on forcible redistribution of low incomes by some outside agency. But as the majority of such low incomes are also insufficient to provide for "reasonably adequate" housing, clothing and recreation, this argument seems to apply equally well to whatever such an outside agency might decide to be necessary.

OVEREMPHASIS OF MEDICAL CARE

This tendency to single out and exaggerate the imperative necessity of medical care as compared with other things, also essential to the preservation of health, runs through most discussions of sickness insurance. For instance, in publication no. 27 of the Committee on the Costs of Medical Care entitled "The Costs of Medical Care," prepared by certain members of the committee's research staff, the following statement appears:² "The people of the United States, as represented in these surveyed communities, are not receiving medical care adequate to their needs or equal to the possibilities afforded by the present state of medical art and science." Exactly the same could be said of housing, clothing, education, food or almost any other essential of a healthy life. If health alone is concerned, it has frequently been demonstrated that various measures such as sanitation and improved housing will reduce mortality and morbidity, something no one has ever been able to show for insurance medical service.

2. Costs of Medical Care. Publication No. 27, Committee on the Costs of Medical Care, University of Chicago Press, 1933, p. 191.

Even with such a proved method of health improvement as better housing, the best intentioned efforts of philanthropists to reconstruct the budgets of those whose incomes must still remain below good health standards are apt to produce unexpected and often undesirable effects. An illustration of such effects in this field is given in a recent statement of G. C. M. M'Gonigle, medical officer of Stockton-on-Tees, an English town not far from Durham. He compared the health conditions in a slum area with those in a recently constructed model housing project and said:³

Briefly, following the closest and most careful examination of all the facts and figures available, and investigation of all the conditions and all the factors that might conceivably be concerned, the conclusion reached was that from the health point of view the transferred group was in a less satisfactory state than the group resident in the bad old slum area; that there has been definite deterioration in the health of the transferred group and that between the two the only outstanding difference was in regard to diet.

The folks in the slums were called upon to pay less for housing and had more to spend on food; those with the fine houses had to pay for the fineness, and to do so had to go short at mealtimes. In a word, they had to kill themselves in order to be able to live in dwellings guaranteed healthy, and the alternatives with which the slum dweller appeared to be faced are of remaining in his slum, feeding fat, and taking a chance on its killing him; or moving into a high-grade dwelling and living healthily until death from starvation supervenes.

The arguments as to the extent of sickness and the amount of medical care are presented in the conclusions of the Committee on the Costs of Medical Care in the form of statistical tables and graphs some of which appear to be open to question.

ECONOMIC MEASURES OF MORBIDITY

It seems justifiable to presume that an economic measure of morbidity was considered by those who collected the data and analyzed the figures given in publication no. 27, "The Costs of Medical Care," when we examine the definition of illness given on page 8 of publication no. 26, prepared by members of the Committee's research staff. This definition, which we

³ Letter from Great Britain, *Am. J. Pub. Health* 23:726 (July, 1933).

must assume was kept in mind in all of the discussions and analyses made by the research staff, reads as follows:

For the purposes of this study an illness is defined as any disorder which wholly or partially disables an individual for one or more days or as an experience for which medical service of any kind is received. Any condition, symptom, or disorder for which drugs costing fifty cents or more are purchased, is considered an illness.

This definition names three conditions, any one of which is accepted as proof of "illness." The first is "any disorder which wholly or partially disables an individual for one or more days." This is practically identical with the "incapacity for work" standard of illness which has, in the opinion of many students of vital statistics, rendered insurance morbidity statistics almost valueless. The reason given by students for rejecting such statistics as measures of true morbidity is that this standard is fundamentally an economic rather than a pathologic test of illness.

The second condition accepted as proof of illness is "any experience for which medical service of any kind is received." It should be noted that the definition does not state any experience which the physician who gives the medical service diagnoses as an illness. Moreover, the research staff included under such medical services the attention given by chiropodists, optometrists, osteopaths and other sectarian practitioners. It does not appear to be clear that the illnesses measured by this second condition are necessarily of pathologic origin in every instance. Under this condition it might reasonably be assumed that medical services of some kind might be "received" for purely economic reasons.

The third condition accepted as a measure of morbidity is "any condition, symptom, or disorder for which drugs costing fifty cents or more are purchased . . ." Can it be successfully denied that the purchase of drugs is an economic experience or expenditure or that the inclusion of such an experience or expenditure in the basic definition of illness does not indicate that the committee or the research staff presumably intended to consider economic expenditure as a measure of morbidity?

Furthermore, experience in many countries having compulsory sickness insurance systems, where such statistics of "morbidity" have been collected meticulously over many years, and have been based on standards strikingly similar to those contained in the "definition of illness" used by the Research Staff of the Committee on the Cost of Medical Care, demonstrates that those statistics can be arranged in tables and graphs, which, if improperly labeled or unaccompanied by detailed explanation, may lead to erroneous impressions and deductions.

EXPENDITURES AS MEASURE OF MORBIDITY

The fundamental figures as to the amount of "illness" in various income classes, on which all subsequent argument rests, are based on the common error of writers on sickness insurance that economic expenditures for medical care are a measure of morbidity. True, some of the writers indicate surprise that this method leads to the conclusion that morbidity increases with income. They do not seem to realize that they have not been measuring morbidity but only expenditures for medical care.

It appears from the studies of the Research Staff of the Committee on the Cost of Medical Care that the rich pay more for medical service than do the poor. It is claimed that these studies have shown for the first time "the striking fact that spendable incomes and costs of medical care are closely correlated." On page 162 of publication no. 27, "The Costs of Medical Care," appears this statement:

Where the people have more wealth they spend relatively more for medical care, and where they are poorer they spend relatively less. Not only wealth, but the proportion of wealth which is available in a spendable form, influences expenditures. The costs of medical care appear in a different light and are judged against different standards by the city dweller accustomed to receive all his income in cash, and by the farmer of equal total wealth who handles little money in the course of the year. Medical care is generally a "cash commodity" purchased with spendable income. A \$25 charge by a physician or dentist may be received with composure by a resident of Philadelphia who has a cash income of \$1,500; but it may be "viewed with alarm" by a farmer in Vermont with a money income of \$300 or by a farmer in Georgia with \$100,

despite the fact that the farmer may have a total annual income worth \$1,500 and despite the fact that \$25 might pay for twice as much medical care in the rural area as in the urban community.

This distinction between "spendable" and other income is not original. Economists for at least a century have known that demand in a money economy depends on the supply of money in the hands of possible purchasers, and that wherever a "household economy" still exists, where most of the goods produced are consumed by the producers, there is less effective demand for goods or services that must be paid for in cash.

One of the important conclusions which may be drawn from this distinction between wealth and spendable income in relation to proposals to introduce state wide, compulsory insurance systems, seems to have been entirely overlooked. That conclusion is that any such system which calls for uniform cash contributions for its support will be entirely unsuited to rural districts where production for use is still the dominant form of economic organization. This difficulty is not a theoretical one. It has already compelled important local modifications in some European sickness insurance systems.

They seem to be surprised to find that "the striking fact is that spendable incomes and costs of medical care are closely correlated."⁴ So are "spendable incomes" and the costs of travel, shelter, clothing and everything else, but this is scarcely a "striking fact."

FUNDAMENTALS OF MEDICAL CARE

An elaborate study, publication no. 22 of the Committee on the Costs of Medical Care entitled, "The Fundamentals of Good Medical Care" was made to determine "medical services needed." It is suggested in this study that for a standard population group such as that of the United States in 1930 in which all factors of "age, race, sex and geographical distribution" are considered, giving due regard for the different requirements of males and females, old and young, 5649.5 medical services are needed for each 1,000 persons.

4. Costs of Medical Care, Publication No. 27, Committee on the Costs of Medical Care, University of Chicago Press, 1933, p. 160.

Although no studies in foreign countries have come to our attention that have been conducted on exactly the same lines as the one made for the Committee on the Costs of Medical Care, some British figures have been collected which seem to have some significance in this connection. In 1923 the Ministry of Health of England made an examination of the medical services rendered to insured persons during the whole of 1922.⁵ The statistics were based on 446 practices having aggregate lists of 736,000 insured persons. The average annual number of attendances recorded was 3.4 per person, but allowing for possible failure to record all attendances the number was taken to be 3.5. The British study was made to determine the amount of work and likewise the proper pay for care under insurance. It would appear that the study made for the Committee on the Costs of Medical Care might likewise serve for a similar purpose since it is used for a comparison of costs based on this and other estimates of care received, and the charges made in certain insurance and contract systems of medicine.

The British study was made on a somewhat different classification than that found in the Committee on the Costs of Medical Care study, but the British study included all the services asked for by patients to whom the services were freely provided and in a system where there are repeated charges that the demand for service is in excess of the need. Yet these patients *asked* for only 62 per cent as many services as are *recommended as necessary* in the study for the Committee on the Costs of Medical Care which "are frankly founded on arbitrary judgment."⁶

There seems to be a further suggestion of similarity between these two studies since the footnote carried under the summary table in the Committee's report states,⁷ "For illness only. Excludes calls for preventive service." The British health insurance system is so

5. McCleary, G. F.: National Health Insurance, London, H. K. Lewis & Co., Ltd., 1932. p. 117.

6. The Fundamentals of Good Medical Care, Publication No. 22, Committee on the Costs of Medical Care, University of Chicago Press, 1933, p. 11.

7. Medical Care for the American People, Publication No. 28, Committee on the Costs of Medical Care, University of Chicago Press, 1932, p. 8. See also Publication No. 26. The Incidence of Illness and the Receipt and Costs of Medical Care Among Representative Families, University of Chicago Press, 1933, p. 126.

weak on the side of preventive medicine that practically no services for that purpose are included.

SERVICES ASKED FOR UNDER INSURANCE

The number of services estimated in the publication of the Committee on the Costs of Medical Care as necessary for good medical care, viz., 5,649.5 per 1,000 persons, is for "home, office and clinic calls" by physicians. The English study reported by McCleary included domiciliary and surgery services. (A physician's office is called a "surgery" in England.) Clinic services, such as are known in the United States, are not common in connection with health insurance.

If for the sake of argument we may be allowed to reduce the 5,649.5 "needed" services per thousand persons annually to a more general and less accurate term, namely, 5.6 *needed* per individual annually, the comparison of this figure with 3.5 *demande*d services, annually, in Great Britain, shows a considerable difference, which is made more significant by the authors of the Committee's publication no. 22, who warn the reader that "if he expects to find here finality of judgment and precision of detail, he is doomed to disappointment." Moreover, it is stated that "this report makes no attempt to measure the effective demand for medical care" which is apparently recognized as something quite different from an arbitrary estimate of needed care.

It is principally from the study on "The Incidence of Illness" that the conclusion is drawn that a large percentage of the sick are denied medical service because of inability to pay. Whether this conclusion is true or not the evidence submitted is not sufficient to prove.

Evidence of this denial of service is supposed to be furnished by a tabulation of the "Percentage of Families Receiving Certain Medical Services."⁸ This table shows that this percentage increases fairly regularly in proportion to income. For example, 82 per cent of the illnesses (as previously defined) among families with an income of less than \$1,200 received the attention of a physician as contrasted with 96.2 per cent

8. The Incidence of Illness and the Receipt and Costs of Medical Care Among Representative Families, Publication No. 26, Committee on the Costs of Medical Care, University of Chicago Press, 1933, p. 92.

receiving such attention in families with incomes of more than \$10,000 annually. A few neurasthenic persons in the comparatively small group with such large incomes may have distorted these figures, based on an economic definition of illness. There are a number of other unmentioned factors, such as source of diagnosis, which throw doubt on the validity of the proof on which the conclusions are based. On the other hand, if the reasoning is accepted it proves too much, for the greatest difference in care received by the different income classes is not found in relation to the attendance of a physician, surgeon or nurse, or of hospitalization, but in the care of "secondary practitioners and cultists." While only 5.5 per cent of those under the \$1,200 income and but 6.3 per cent of those receiving between \$1,200 and \$2,000 receive the services of chiropractors, naturopaths, etc., 24.2 per cent of those with over \$10,000 a year income receive these blessings.

WAS MEDICAL SERVICE NEEDED?

There seems to have been no attempt to determine whether the difference in the amount of medical service given to the various income classes is due to neglect of diseases needing this service or to excessive care of what German physicians call "bagatelle cases," where such service is little needed. The investigators did find that 29.67 per cent of the illnesses were classified as "minor respiratory." If only one half of these failed to receive medical care in the lower income classes, it would be almost sufficient to account for the entire difference in the amount of such care between the lowest and the highest classes. There is no claim that this is the explanation, but only that the omission of all consideration of this quite possible contingency throws serious doubts on the methods and conclusions of the investigation.

On page 54 of this study one is told that "nearly one-half the persons (47.1 per cent) suffered no single recognized attack of disease during the year." The percentage of those with an annual income of less than \$1,200 without any illness is given as 48.8 per cent. On page 101, table 21, it is stated that 43.4 per cent of those with an annual income of less than \$1,200 and 47.9 per cent of those studied in all income classes

had the services of a physician. Of this table the report says, "Considered in the light of any appropriate standards of good medical care, the figures are appalling." Again on page 103 it is repeated that, "these figures point to an appalling neglect of health and disease."

These figures seem to indicate that 51.2 per cent (p. 54) of those in the low income class reported illness according to the definition previously quoted, and that 43.4 per cent (p. 101) received the services of a physician, leaving only 7.8 per cent without such services. Perhaps a regrettable but scarcely an "appalling" situation.

The table on "The Distribution of Sickness Costs,"⁹ while it shows the wide variations in the amounts paid by the various income classes, makes no apparent attempt to adjust these charges to determine the effect of reductions in the price of services to the lower income classes. It is easily possible that in some cases equivalent services were received, and it is practically certain that the difference in services is by no means expressed with any statistical accuracy by the figures given.

It is not the fact that there is some, probably important, difference in the services received by different income classes that is challenged, but that the degree of difference is in any way statistically measured or stated by these methods.

The statistical comparisons of medical attention received in proportion to income are vitiated by the apparent lack of any attempt to determine the character of the sickness that was neglected and the extent to which medical service was actually desired by and denied to those in need of it. To deny that there is any unsatisfied need for medical services would be as unjustifiable as to accept the conclusions of the Committee on the Costs of Medical Care as to the extent of that unsatisfied need. In the same way, to deny the possible value of some form of distributing the cost of medical care would be as unfair as to accept the

9. Medical Care for the American People, Publication No. 28, Committee on the Costs of Medical Care, University of Chicago Press, 1932, p. 17.

Committee's conclusion that insurance (which experience indicates would about double the recorded "morbidity") is a solution.

COSTS IN GROUP CLINICS

There seems to be a similar bias running through several of the reports. The one on "Private Group Clinics," publication no. 8, is made the basis of much argument in the Majority Report as to the superiority of medical groups in any system of medical care. This is a debatable question, and no criticism is suggested here of the value and place of medical groups. A vital point in this study is table 7 on page 75 on "Gross and Net Clinic Income per Practitioner in 27 Private Group Clinics, 1929." In the first place the number of groups studied is manifestly so small in relation to the total known number as to render any conclusions unsafe. While this study estimates the total number of groups in the United States at 150, a study made by the Bureau of Medical Economics located over 300 that possess the characteristics of those included in the study of the Committee on the Costs of Medical Care. The 27 selected for study in the committee's report have an average membership of 11.6 physicians, while the average for the 231 included in the bureau's study was between 6 and 7. Thus there appears to have been a selection of this small group of clinics.

It may be urged that careful individual statistical study of these clinics, which it is manifestly impossible to make for the entire group, lends greater reliability to these figures. Against this claim for accuracy may be instanced the fact that while this study is used as a basis of conclusions that overhead costs are reduced in groups, for one of the clinics so studied "the net clinic income per practitioner" is given as \$844 more than the gross income.

The studies that were made of various prepayment and individual schemes throughout the country seem to have been selected to show only the favorable results which would support the conclusions arrived at in the Majority Report. When a wider study of industrial groups was attempted all reference to the character of the medical service was omitted.

This tendency to exaggerate the facts detrimental to present conditions and to neglect proper modifications

of statistical statements is supplemented by an exactly opposite bias in the treatment of schemes of medical care involving the insurance principle, all of which seems to be in preparation for the endorsement of sickness insurance in the majority report of the Committee on the Costs of Medical Care. This is the same sort of bias that has characterized the publications of the International Labor Office and a host of propagandists of sickness insurance. The facts are not misstated, but they are selected and overemphasized. Offsetting data and modifications are omitted or neglected.

No one would deny that the unequal distribution of incomes and the incidence of disease and of medical facilities may cause many people to suffer from lack of medical care or may impose almost unbearable burdens on many families and individuals. The extent of these evils is of great importance, however, in determining whether it is necessary to enter on a wholesale transformation of social, economic, political and medical institutions, such as is involved in the introduction of compulsory sickness insurance.

CASH BENEFITS UNDER INSURANCE

The Committee on the Costs of Medical Care asserts that any effective system of sickness insurance must be compulsory. Although it advises against the recognized and inevitable evils that accompany the combination of cash and service benefits in the same system, it is evidently aware of the fact that such separation would deprive the scheme of its attractiveness to forces that might be essential to a campaign for its introduction. Therefore, after having ostentatiously put cash benefits out of the front door of its proposed system, it welcomes them back to the rear entrance as follows:¹⁰

Undoubtedly the difficulties over medical certificates have been due in part to hasty and incomplete examination of the patient, and to failure to keep good clinical records. Plans of insurance for medical service, developed as such, with high standards of professional service to patients, would provide a foundation from which the medical problems of cash benefits

10. Medical Care for the American People (Majority Report), Final Report of the Committee on the Costs of Medical Care, University of Chicago Press, 1932, p. 50.

could be more successfully met. The specific recommendations made by the Committee in a later chapter are framed with this policy in mind.

Here is the old attempt to make the physician the scapegoat for the abuses of a combination of cash and service benefits and to clear the road for their combination with all the accompanying abuses.

Incidentally there is little indication that in existing systems "the difficulties over medical certificates have been due in part to hasty and incomplete examination of the patient, and to failure to keep good clinical records." None of the multitude of official and private investigations of this subject has ever listed this as a major reason for such "difficulties."

Even this position is not satisfactory to many of the advocates of insurance, who object to any proposal to separate cash and service benefits. A recent work, after rebuking the committee for its criticism of such a combination, says: ¹¹

In reality, no system of legislation can escape some conflicts of social and economic forces. Just as it is natural for the small business man in the United States to complain against the chain stores and trusts, it is natural for the medical practitioners abroad to complain against a gigantic system of health insurance which can sell and dispense medical care and drugs at wholesale rates.

Surely no comment is required to show how this quotation justifies all that has been said about the attitude of the advocates of insurance and their desire to force medicine into industrial and commercial patterns.

GROUPS UNDER INSURANCE

A central feature of the plan advocated by the majority of the Committee on the Costs of Medical Care is

11. Epstein, Abraham: *Insecurity: A Challenge to America*, New York, Harrison Smith, 1933, p. 462. This work is an excellent example of the sort of information brought to this country concerning the operation of European systems. Three quotations will illustrate this: ". . . all compulsory plans allow the free choice of a doctor" (p. 462). Concerning admission to insurance practice: "Any duly qualified physician may apply for inclusion in the approved list. The organization responsible for the establishment of the medical service has no right to refuse him" (p. 485). "In addition to the curative treatments through chains of sanatoria and clinics, the insurance institutions are doing a great amount of educational work. The preventive work has enabled all countries to *reduce their morbidity rates* and increase the life expectancy of their people" (p. 485 [*italics ours*]). A minimum of investigation would have proved the falsity of all three statements.

the old "group" scheme favored by all the lay insurance carriers of Europe and condemned by all medical authorities. Indeed, one is told¹² that the absence of such medical groups is "one of the chief disadvantages which European countries have faced under compulsory insurance." This seems to show an amazing ignorance of the vast systems of medical groups established by insurance societies in Germany, Austria, Poland and other countries, some of which have been abandoned under the criticism of the character of the service by the medical professions, and others by the societies themselves because of their financial and medical failure. It takes no note of the fact that such groups are practically forbidden under the insurance laws and regulations of the most successful systems, those of England and France, and that this prohibition is the result of the study of their operation in these countries.

When this recent agitation, centering around the work of the Committee on the Costs of Medical Care, is thus analyzed, it is seen that nothing fundamentally different from what exists in European systems is proposed. That few safeguards against the worst of the evils in those systems are suggested and that, therefore, what has been said about those systems applies to its proposals.

This criticism does not in any way intimate that there is no need for action looking to improvement of the medical care received by many in the lower income classes, nor even that there is not much room for improvement in methods of distributing the burden of that care. A large number of local and state medical societies are working to solve these problems. They recognize that the question of adequate medical care for the people is not one problem to be solved by a wholesale social panacea like sickness insurance. There are a multitude of detailed local, state and national problems, none of which can probably be "solved" with finality, but all of which offer opportunity for study, experiment and improvement.

12. Medical Care of the American People (Majority Report), Final Report of the Committee on the Costs of Medical Care, University of Chicago Press, 1932, p. 129.

INSURANCE NOT BEST SOLUTION

The amount of money and ability that can be devoted to health care is still limited. The question of which manner of application will do most to reduce actual morbidity and mortality is not simple. The sums required for general compulsory insurance are so tremendous that, as experience in other countries has proved, the amounts available for other forms of health care are reduced. At a recent meeting of the Royal Sanitary Institute of Great Britain, the president, Sir Henry Brackenbury, quoted two statements of the British Medical Association to the Royal Commission on Health Insurance in 1925.¹³

The first is this:

The measure of success which has attended the experiment of providing medical benefit under the National Health Insurance Acts system has been sufficient to justify the profession in uniting to ensure the continuance and improvement of an insurance system." The second is this: "The organization of a national health insurance scheme is not necessarily, or even probably, the best means of utilizing limited resources for the promotion of national health. It is more than likely that there are a number of other directions in which, severally or collectively, a corresponding expenditure would produce an even more satisfactory return.

Commenting on this, he said:

Those statements were made more than eight years ago. There can be no doubt, however, that, contradictory as some may think they appear to be, they are both regarded as true by the great majority of the medical profession today.

At the meeting of the House of Delegates, at Cleveland, in 1934, the question of experimentation conducted under the auspices of medical societies was carefully considered. Ten principles to guide County Medical Societies were adopted in the report of the Reference Committee which read in part as follows:

If it is determined in a community that some experiment to change or improve the method of administering medical service is desirable, observance of these principles will remove many of the "disturbing influences" from such an experiment. In all such experiments, attention must be sharply focused on the quality of medical service.

13. Brackenbury, H.: J. Roy. San. Inst. 54: 47 (Aug.) 1933.

Such restrictions will undoubtedly lower the enthusiasm of many of the present advocates of such schemes. They remove the interest of the politician, the commercial promoter and all those who consciously or unconsciously are seeking to achieve other objectives than better medical care for those unable to provide such care for themselves under present conditions. All these principles are directed toward protecting the character of the service to be given and all are directly designed to guard against abuses which experience shows are bound to arise when these principles are neglected. In most communities it will be found that comparatively few changes in the methods of administering medical care will be necessary. That type of medical practice which preserves the personal relationships between physician and patient, that maintains the practice of medicine as a profession, and that has withstood the test of centuries must be preserved for the best interests of both the public and the medical profession.

The House of Delegates adopted the following principles to be followed by all constituent bodies of the American Medical Association as bases for the conduct of any social experiments that may be contemplated by them:

First: All features of medical service in any method of medical practice should be under the control of the medical profession. No other body or individual is legally or educationally equipped to exercise such control.

Second: No third party must be permitted to come between the patient and his physician in any medical relation. All responsibility for the character of medical service must be borne by the profession.

Third: Patients must have absolute freedom to choose a legally qualified doctor of medicine who will serve them from among all those qualified to practice and who are willing to give service.

Fourth: The method of giving the service must retain a permanent, confidential relation between the patient and a "family physician." This relation must be the fundamental and dominating feature of any system.

Fifth: All medical phases of all institutions involved in the medical service should be under professional control, it being understood that hospital service and medical service should be considered separately. These institutions are but expansions of the equipment of the physician. He is the only one whom the laws of all nations recognize as competent to use them in the delivery of service. The medical profession alone can determine the adequacy and character of such institutions. Their value depends on their operation according to medical standards.

Sixth: However the cost of medical service may be distributed, the immediate cost should be borne by the patient if able to pay at the time the service is rendered. ("Immediate" in this connection is here interpreted as meaning that at least a part of the medical service should be paid for by the patient at the time the service is rendered.)

Seventh: Medical service must have no connection with any cash benefits.

Eighth: Any form of medical service should include within its scope all legally qualified doctors of medicine of the locality covered by its operation who wish to give service under the conditions established.

Nine: Systems for the relief of low income classes should be limited strictly to those below the "comfort level" standard of incomes.

Tenth: There should be no restrictions on treatment or prescribing not formulated and enforced by the organized medical profession.

The importance and usefulness of the foregoing principles were again recognized by the House of Delegates in the resolution adopted at the Special Session held February 15 and 16, 1935, which read in part as follows:

In the establishment of all such plans, county medical societies must be guided by the ten fundamental principles adopted by this House of Delegates at the annual session in June 1934.

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