



them are not essential to the production and distribution of professional services. They are not only not essential to, but many of them are destructive of those services, and therefore all professions, and especially the medical professions, have been compelled to fight, as a condition of preserving the value of their services to the community, all efforts to mold them into the patterns of industrialism.

Industrialism introduced a number of new uncertainties peculiar to itself. It caused great shifts of population. It introduced cyclic swings in production with alternate periods of surplus and shortage, overwork and unemployment. Mechanical progress and invention destroyed and created occupations, displaced thousands and gave employment to other thousands. These uncertainties and resulting calamities were as uncontrollable by the individual as earthquakes, fires and shipwrecks, while the sufferers from these happenings no longer had the personal sources of relief that existed under feudalism.

A vast amount of poverty was thereby created, although probably no more and possibly much less than existed in previous social stages. This poverty was, however, concentrated in certain social classes and was far more dramatic than the poverty of feudalism.

The struggle against the evils of the poverty created by industrialism takes on two forms. One seeks to alter the social organization so as to increase insufficient incomes. The other, supported by those who believe such alterations impossible or that they might bring worse conditions, accepts the fact of insufficient incomes as inevitable and directs its energies toward alleviation. Those who support the latter course of action can claim much of the credit for the great mass of so-called humanitarian legislation enacted during the nineteenth and twentieth centuries. They advocated and secured legislation against the worst factory conditions, secured the restriction of child labor and have been the most active supporters of social insurance, which has aimed primarily to supplement and manage the expenditure of insufficient incomes rather than to increase them to the point of sufficiency. Humanitarian legislation and social insurance would relieve industrial poverty by substituting social responsibility for personal responsibility.

There has never been a clear division of attitudes and activities between these two lines of attack on the problem of poverty. There have been frequent shiftings and combinations of forces that have confused these lines, but the distinction has remained sufficiently clear to be helpful in understanding many of the origins and present characteristics of social insurance.

It was as a natural resultant of these forces that Germany in 1883 became the first country to adopt compulsory insurance as a method of meeting the poverty caused by sickness. Germany was late in entering on the industrial revolution. There were large remnants of feudal institutions, and the popular mind was filled with feudal traditions. The working class was pressing politically for revolutionary changes in the industrial organization as a means of abolishing poverty. Bismarck's explanation of how he introduced sickness insurance in order to attract German laborers from social democracy has often been quoted. But less emphasis has been laid on the argument, which accompanied this explanation, to the effect that a benevolent "welfare state" would secure the allegiance of the population to the crown. Any one who looks into the great mass of German writings in praise of this "welfare state" cannot but observe how much of the reasoning and argument is derived from feudalistic ideas of mutual loyalty between the common citizen and the overlord, church or guild.

A recent German writer <sup>1</sup> thus describes the origin of insurance:

Social insurance is the child of its period. It is the result of a compulsory urge to organization and had its origin in the mechanical conception of life. . . .

The increasing industrialization of Germany had need of a healthy, efficient working force for its development, and the Kaiser needed soldiers. . . .

Bismarck's original plan arose out of a combination of the capitalistic with the feudal and fraternal mental attitude. Governmental care was to make it clear to the eyes of the workers how much the state cared for them and thereby make them contented and loyal.

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1. Pick, Gottlieb: *Sozialversicherung und Aerzte*, 1931, pp. 5-6. See also von Weizsacker, Victor: *Soziale Krankheit und der Soziale Gesundheit*, 1930, p. 7.

Austria, with much the same stage of development, followed in 1887. Other nations showed few signs of following this example during the nineteenth century. But the first decade of the present century saw a remarkably rapid expansion of sickness insurance among European states. Tables 1, 2 and 3 give the date of the introduction of such systems among the principal nations and also something of the extent of their expansion within those nations.

Many of the early features of sickness insurance have set their stamp on all subsequent evolution. A most significant fact is that it was in its origin only most incidentally insurance against sickness, being primarily directed against the unemployment caused by sickness. It was not designed to cover minor sicknesses but only those depriving the family of the services of a bread winner. At this time sickness was probably the principal cause of unemployment. At any rate there was a popular opinion that it was almost the only justifiable cause for unemployment. "Able bodied idle" was a term of reproach, and such unemployment, if occasionally recognized as unavoidable, was looked on as temporary and requiring no special social action.

(The only purpose that was emphasized in the early years of insurance was the financial assistance given while the wage earner was incapacitated for work. The entire organization was formed to fulfil this purpose. There was slight mention at that time of the necessity and value of medical care, and certainly none of the claims concerning the beneficial effects of such care on the public health that later came to be the principal arguments for the adoption of sickness insurance.)

Previously existing institutions were incorporated into the legal systems of sickness insurance and determined its form of organization. The most important of these institutions were the mutual aid societies, some form of which had existed among laborers for centuries. Although these were by no means suited to the purposes of conducting such great schemes of financial administration and medical care as were created by the sickness insurance legislation, they have become the dominant administrative agency of nearly all such insurance systems. Since they had been organized almost exclusively to give *financial relief* in time of sickness,

they originally considered *medical care* as purely incidental.

According to authorities in Germany, Austria and Switzerland, physicians usually donated their services to these early societies or accepted purely nominal fees, considering such services as their contribution to the charitable work of the societies.<sup>2</sup> The practice of medicine then was much less complex than it is today. The physician carried practically all his available equipment in his handbag. There were few hospitals and practically no laboratories, clinics, physical therapy or other extensive and expensive features of modern medicine.

Sickness insurance originated from a variety of motives, often contradictory, and has pursued a number of conflicting objectives. To be sure, this condition is not peculiar and is shared, though hardly to the same extent, by other social institutions. The question of whether it is fundamentally philanthropy, analogous to poor relief, and therefore a function of the "welfare state," or whether it is a form of insurance, as its name indicates, has never been settled. German political and social theorists have long delighted in debating this question.<sup>3</sup>

No system of sickness insurance is supported entirely by the contributions of its beneficiaries. This is true even if employers' contributions are included, and the consequence is that in most countries the contributions from taxation are a large percentage of the insurance income. For reasons that will be discussed more fully, the sickness risk is not one that lends itself to actuarial accuracy.

The organization of sickness insurance in a democracy always has important political results. Although it is always urged in the interests of underpaid workers, these have never been responsible for or even highly favorable to its enactment. Instead, laborers have demanded that wages be sufficiently high to enable the recipients to pay their own medical expenses. In no country have the unions led a demand for sickness insurance. In nearly every country the first attempt to collect sickness insurance contributions from employees

2. Stritzko, Joseph: Die Aerzte Oesterreichs und die Sozialversicherung, in *Die Arztfrage*, 1926, pp. 108-109. Narbeshuber, Carl: *Revue Internationale*, November, 1929, p. 52.

3. Weddigen, Walter: *Grundfragen der Sozialversicherungsreform*, 1931.

has met with resistance. It was so in Germany a half century ago and in France in 1931. The political parties of labor have never made sickness insurance one of their urgent planks. No system owes its introduction primarily to any socialist or labor party.

The story of Germany is typical and has been told many times. Bismarck introduced the law as a weapon against the Social Democrats, who voted unanimously against it. For years this party fought all forms of social insurance, denouncing them as a "beggars' soup kettle," from which relief was ladled out to prevent discontent. Then the Social Democrats captured the insurance societies and made them a part of their political machine, whereupon these institutions became "sacred cows" to be defended against all criticism. The benefits of social insurance, which Bismarck expected to use to buy support for the imperial government, were then used to buy Social Democratic votes.<sup>4</sup> The latest development has been the seizure of these institutions by the Nazis, who are now using them to crush out Social Democracy.

The situation was much the same in other countries. In an address to the International Conference of Insurance Societies, Dr. Winter, delegate from Czechoslovakia, said: <sup>5</sup>

Sickness insurance was introduced into the countries of Central Europe, into Germany, and later into Austria, at a time when the working class was largely powerless in the political field. The motives, always political, which led to its introduction are well known. The working class was not represented in the political institutions but it was left in control of the insurance societies.

He then describes how this control of the societies was turned into a political weapon. Of Austria we are told: <sup>6</sup>

The societies are the pillars of the political parties. They have been so anxious to give benefits to the insured that they are today in a miserable financial condition. In spite of the magnificent palaces they have constructed to shelter their services, all this is only a deceptive show.

Great Britain repeats the story. The law was enacted as a political measure by Lloyd George, and the socie-

4. Baeumer, Waldemar: *Die Krankenversicherung*, 1930, pp. 9-14.

5. *Compte Rendu*, 1930, p. 35.

6. Narbeshuber, Carl (president of the Austrian Medical Association): *Revue internationale*, November, 1925, p. 54.

TABLE 1.—Provisions of National Sickness Insurance Systems \*

Date of Enactment of Law	Qualifications for Insured		Population	Number Insured and Beneficiaries						Physicians		
				Number Insured				Total Beneficiaries, Including Families		Engaged in Insurance		
				Compulsory		Voluntary						
				Compulsory	Voluntary	Number	Per Cent	Number	Per Cent	Number	Per Cent	Total in Country
Germany Industry, 6/15/83 Commerce, 1885 Industry, 1886	All salaried and wage workers, domestic apprentices; professors, teachers, etc., under 2,700 M. annually	a. Former compulsorily insured b. Small employers, 2,700 M. maximum c. Families of insured	63,000,000	19,800,000	31.4	1,600,000	2.5	40,000,000	63.5	50,000	35,000	70
Austria 1887; modified 28 times since and extended	All wage workers (no wage limit) except artisans and independent workers	a. Former compulsorily insured b. Small employers	6,300,000	.....	....	63,000	1.0	4,800,000	76.0	8,000	7,500	94
Bulgaria 1918; modified 3/6/24 and 2/2/29	All employed workers and small employers; limit, 2,000 Swiss Fr.	a. Former compulsorily insured b. Public employees c. Merchants d. Liberal professions (limit 2,000 levass)	5,800,000	230,000	3.9	2,000 to 3,000	0.39	Does not include family	....	2,300	1,100	48
Belgium Proposed	Proposed; all wage workers	.....	8,060,000	2,200,000 (proposed)	26.0	?	....	6,000,000 (proposed)	75.0	5,500	.....	..
Denmark 1892; modified 1915, 1921-1927, 1933	Not compulsory†	All persons with low incomes, regardless of occupation	3,500,000	Not compulsory†	....	1,558,000	65.1	Does not include family	65.1	2,000	Great majority	..
Danzig Same as Germany	All wage workers under 4,500 M.	All persons insured for 28 weeks of preceding year	407,500	?	....	?	....	200,000	49.0	282	200	67

		Very few in private organizations	1,200,000	40,000	3.3	.....	....	90,000	7.5	.....	.....	..
		[All earning less than 18,000 Fr. (15,000 Fr. in provinces)]	11,000,000	8,000,000	19.0	.....	.....	12,000,000	29.0	27,000	18,000	66
		a. Former compulsory b. All earning less than 15,000 Fr.									(?)	
	By : new	a. All manual workers b. All nonmanual receiving less than £250 annually	44,500,000	17,500,000	....	300,000	....	Does not include family	....	36,000	17,700	49
	Force as whole, 3	(Accident insurance only); all workers under 8,000 Fl. ann.	7,800,000	1,227,500	....	1,160,000	....	Does not include family	....	4,450	3,700	84
		Open to all										
			8,000,000	1,700,000	9.3	Not stated	....	Not stated	....	.....	.....	..
		a. Former compulsory b. Independent artisans c. Small employers; limit, 8,400,000 Cr.										
			1,900,000	145,000	7.0	.....	....	240,000	12.5	1,062	600	56
			285,000	64,800	22.7	416	0.15	110,000	88.6	180	165	80
		Not compulsorily insured (domestics, small employers, etc.); limit, 12,500 Fr.										
			2,800,000	550,000	19.6	80,000	2.85	1,500,000	43.5	1,800	"Nearly all"	..
		All receiving less than 5,400 Kr. annually										
			919,400	(None)	....	18,000	....	35,000	....	600	70	11.6
		All members of labor organizations										

\* Compiled from replies to questionnaires by International Medical Association, as published in Revue internationale de médecine professionnelle et sociale, August 1931, corrected from all available later information.

† Made compulsory in October 1933.

TABLE 1.—Provisions of National Sickness Insurance Systems\*—Continued

Date of Enactment of Law	Qualifications for Insured		Population	Number Insured and Beneficiaries						Physicians		
				Number Insured				Total Beneficiaries, Including Families		Total in Country	Engaged in Insurance	
				Compulsory		Voluntary					Number	Per Cent
				Number	Per Cent	Number	Per Cent	Number	Per Cent			
Poland 5/19/20	All employees (no wage limit) save agricultural, ecclesiastic and governmental	Former compulsory under 45 years of age	31,000,000	3,500,000	11.3	(Insignifi- cant)	....	8,000,000	25.8	7,500	2,700	36
Sweden 7/1/33	Not compulsory	All sickness insurance is voluntary	6,000,000	(None)	....	933,000	15.5	3,628,000	60.4	2,300	"Nearly all"	..
Ireland	Not compulsory except in cer- tain cantons	All Swiss citizens	4,100,000	(None)	....	1,400,000	34.0	Does not include family	....	3,350	2,700	80
Czechoslovakia	All wage workers	No voluntary	14,000,000	2,600,000	19.0	56,000	....	10,000,000	73.5	8,000	6,400	80
Estonia	All workers ex- cept domestics, agricultural and governmental	Former compulsory; all wage workers exempt from compulsory	13,500,000	560,000	4.2	2,600	0.02	1,250,000	9.5	3,700	1,300	33.3
Latvia	All workers, employees or domestic	a. Former compulsory b. Home workers										

\*Based on questionnaires by International Medical Association, as published in Revue internationale de médecine professionnelle et de biologie, 1933, and from all available later information.

1933.



ties at once became political forces, antagonistic to many of the best features of insurance.

Sickness insurance has been introduced everywhere with very little consultation with, and often largely against the wishes of, the workers who were to become the patients, and the physicians who were to give the medical service.

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## CHAPTER II

### CHANGES IN INSTITUTIONS AND OBJECTIVES

One of the most striking conclusions that arise from any comparative historical study of sickness insurance systems is their highly experimental character. This is true of the oldest as well as the youngest systems. After a half century of existence, those of Germany and Austria are still changing with great rapidity. These changes are by no means due exclusively to general political, industrial or financial transformations, which often fundamentally alter the workings of the system. They are much more due to constant dissatisfaction with details.

This continuous tinkering creates an extremely complex set of institutions. There are 3,000 sections in the German laws on sickness insurance, and this is only the beginning. The various institutions for the regulation of insurance and the settlement of disputes between contending parties within the system are making new modifications and interpretations almost daily.<sup>7</sup>

An examination of the column headed "Date of Enactment of Law" in table 1 will give some impression of the number of more important fundamental legislative changes in the various systems. A failure to recognize this wide diversity of time and place in the workings of sickness insurance is largely responsible for the contradictory reports and opinions expressed by those who discuss such insurance. A judicious selection of the country and the period in regard to almost any feature will provide authentic examples of almost anything that friends or foes may wish to prove.

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7. "The modifications of the legal institutions have been incessant in Germany, an indication of the difficulty of the social and technical problem to be solved. . . . It is only by *personal solutions*, the English method of trial and error, by the acceptance of an empirical progression, that the best results are obtained" (italics in original). Eyland, J. M.: *Les Assurances Sociales en France*, 1919, pp. 91-92.

An examination of tables 1, 2 and 3 would supply the advocate of almost anything in regard to insurance with information which, if followed by a little investigation, would provide facts to support nearly any argument. This might appear to suggest a simple solution. It might be argued that, if one were to pick out all the desirable features from each system and combine them, one might develop a perfect system. Unfortunately, the problem is not so simple. Some of the desirable and undesirable features in nearly every system are so closely linked by administrative or political considerations as to make separation difficult if not impossible.

The objectives of insurance have been subject to frequent changes of emphasis. While none of the avowed purposes can claim wholly successful realization, yet each change of aim has profoundly affected all phases of the structure and operation of insurance.

The original objective was to share the financial burden, created by the loss of family income and the expense of sickness when the wage earner fell ill. This remains the dominant objective in many, if not most, systems of sickness insurance. But it has been confused with so many other motives, some of which are almost irreconcilable, administratively at least, with the original motive as to lead to destructive conflicts.

This first objective is a direct outgrowth of the feudal idea of solidarity of workers in the same craft. Some of the very organizations that existed under feudalism still function in European systems of insurance, although changed in almost everything but the common tradition. Such groups of fellow workers had little to fear from malingering. Members constantly visited the sick and often assisted in their care. The societies were truly self governing and sufficiently democratic to insure that their officials, who were almost always unpaid, truly represented the membership. They had no need for elaborate financial organizations or expensive headquarters.<sup>8</sup>

The supposition that these conditions could be carried over into the gigantic societies required for the insurance of millions is responsible for many of the evils of

8. McCleary, G. F.: National Health Insurance, 1932, pp. 7-19. International Labor Office, Voluntary Health Insurance, 1927. Lehman, Helmut: *Arzte und Krankenkassen*, 1929, pp. 7 et seq.

present systems. The claim that the great financial and semipolice organizations of paid visitors and supervising physicians, with their intricate statistical reports of expenses and rate of so-called sicknesses are but a larger growth of the old fraternal societies, is but one of the many examples of failure to recognize that a great change in the quantity of any social phenomena almost inevitably changes the quality and character of the institutions involved. This development has almost entirely removed one very important ingredient from the original composition of insurance societies; namely, that element of mutual confidence, personal acquaintance and sense of individual responsibility on the part of the members.

It was impossible to retain the virtues of status under contract. The personal relations that existed under the first disappeared under the second. Each system of social organization has its good and bad characteristics, but the mixture seldom selects all the good features of either and usually leads to conflicts that add new evils.

When the society was thus depersonalized it became a separate entity in the minds of members, who saw important differences of interest arise between them as individuals and the institutionalized organization of which they now generally became compulsory rather than voluntary members. The members were interested in getting as much as possible out of the great financial bureaucracy to which they were forced to contribute.

Just how this change of attitude has affected all the workings of sickness insurance is described by a German physician:<sup>9</sup>

The insured also believe, since they have long contributed to the cost of insurance, that after a certain time *they have a right* to receive some money from it, and only a few workers realize that the existence of an insurance system depends on regular payments from all in order that the individual, as an exception, may obtain something. It is easy to implant the idea in the consciousness of a simple man: "Now that I have paid so long, I will at last get something out of my insurance!"

The fact that demands for damages and for raising the rate of payment are practically unlimited and cost the insured

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9. Kirschner, M.: Zur Praxis der Begutachtung, 1931, pp. 7-8 (italics in original). See also von Weizacker, Victor: Soziale Krankheit und der Soziale Gesundheit, 1930 pp. 7-8. Report of the Departmental Committee on Sickness Benefit Claims under the National Insurance Act (Great Britain), 1914, p. 83.

nothing to bring, and that, if denied, decisions of higher officials may be demanded *without cost or danger*, creates covetousness, quarrelsomeness and simulation: one can at least try everything, and try to drag out a little more; trying costs nothing.

In this way the *ominous will to be sick* is artificially created, and social institutions are many times practically compelled to put a premium on sickness, laziness, exaggeration and deceit, so that the individual, who is in a manner the innocent victim of these compulsory institutions, cannot make any special individual objection. Since legal compulsion has today brought the majority of the population within the scope of social insurance, a constantly increasing proportion of the workers is brought into a condition of subjection to these institutions. Present-day Germany has been compared to a great *Lazaret*, or *home for cripples*, where each individual is trying to get as much as possible out of the gigantic pension cup, which is kept filled by ever higher contributions. Every seventh German is today a social pensioner.

Another aspect of this change in the attitude of the management of the insurance organization is seen in the constantly repeated claim of the officers of the societies to be the only true representative of the insured. This claim has been accepted by all legislators and has been especially emphasized by the International Labor Office in its resolutions and statements, which have had very wide influence on all phases of the insurance problem.

Every institution has a tendency to develop as a sort of social personality, to a considerable degree apart from that of its membership. As its officials and employees increase in number they seek to advance the prestige, increase the size and wealth and add to the power of the institution as such, which, it will also be noted, has a tendency to bring similar advantages to these officials and employees although not necessarily to the members. This is the origin of what has come to be designated as bureaucracy—a development important in many phases of organized medical services.

In every system this bureaucracy grew to amazing proportions. In Germany the number of employees of the Krankenkassen has grown to be practically the same as the total number of physicians employed in giving the medical service.<sup>10</sup> The same ratio seems to hold true in other countries as soon as this bureaucratic tendency has had time to develop. There is continual

10. Pick, Gottlieb: *Sozialversicherung und Aerzte*, 1932, p. 40. Than, Arthur: *Ein systematischer Ueberblick über die gesamte deutsche Sozialversicherung*, 1931, p. 8.

criticism of the sums taken from the contributions for the erection and maintenance of showy headquarters.<sup>11</sup>

In insurance, as in many other institutions, this management soon began to seek other objectives than the mutual welfare of the members. In practically every nation it became a powerful political factor. In so doing it claimed to represent the membership and gained power in proportion as it was able to "deliver" their votes. A slight familiarity with political machines in any country will justify important doubts as to the extent to which the manipulators of such machines are inspired wholly by the interests of those whose votes they control.

The insurance societies especially claimed to represent the members in all the controversies between the physicians and the societies. The society officials assumed that they, rather than the physicians, were competent to decide on the character and amount of medical care to be given. How generally this point of view was accepted is shown by a quotation from an address by Dr. Walter Pryll, general medical counselor to the International Bureau of Labor, to representatives of the various European medical associations.<sup>12</sup> He introduced his address with the statement: "I am charged with indicating to you the general outlines of the Bureau towards the organization of medical service in sickness insurance." He then made the following statements:

The insurance institutions should be able to dispose under suitable conditions of the services of the physicians of which they have need. . . .

The institutions of insurance have the duty of putting at the disposal of the practicing physicians and their patients all the means of prevention and cure offered by modern science: diagnostic centers, dispensaries, clinics, hospitals, sanitariums, etc. . . .

But if on the contrary such institutions are insufficient in quality or quantity or poorly distributed or make excessive charges, it is equally evident that the insurance societies have not alone the right but the duty to create and maintain the indispensable sanitary institutions for the most complete and efficient treatment of the insured.

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11. Baumer, Waldemar: *Die Krankenversicherung, jetzt ein Fluch, umgestaltet ein Segen für das Volk*, 1930, p. 14. Wunderlich, Frieda: *Der Kampf um die Sozialversicherung*, 1930, p. 17. Similar developments in Cuba have been described by Leland, R. G.: *The Practice of Medicine in Cuba*, A. M. A. Bulletin, June, 1933, pp. 92-96.

12. *Revue internationale de médecine professionnelle et sociale*, November 1932, pp. 109-119.

The institutions of insurance which have the responsibility of distributing services to the insured and maintaining the financial balance of their budget should have the right to control the patient and the practicing physicians.

He further declared against free choice of physician, in favor of fee schedules and restrictions on prescribing, criticized professional secrecy, advocated clinics under society management and control of the whole situation by the societies. In short, he put his official position behind the entire program of the carriers and in opposition to the physicians. M. Tixier, chief of the Section of Social Insurance of the International Bureau of Labor, spoke at the same meeting and, with slightly less definiteness, supported the same program. The further significance of these attitudes will become more evident when the place of the International Labor Office in the campaign for sickness insurance is considered.

These insurance institutions, originally formed for mutual financial relief, ultimately became the administrators of a national medical service, often owning the medical equipment and directing the employed physicians.

The consequences of the application of this theory in many countries and the resistance to its application in others make up much of the story of sickness insurance.

The societies are always active in increasing the scope of their activity. Their income is derived from the contributions of the insured, of employers and of the governments. The sums at the disposal of the management are usually a percentage of the sum of this total income. All the power of the societies is directed toward increasing this income. This means continuous pressure for extension of the scope of insurance and for additional benefits. Social insurance, from one very important point of view, consists in determining how a considerable portion of the income of the insured shall be spent. A bureaucracy spending incomes other than those of its members is apt to be generous.

The insurance organization becomes more and more interested in developing its own power and size rather than in furthering the welfare of the insured. Even in such measures as increasing the benefits to the insured it will be guided largely by the degree to which

such benefits increase the importance of the carrier organization. It will exaggerate those benefits which it directly controls and belittle those which might direct the interest and favor of the insured to others. The insurance societies in practically every system have been condemned for their excessive expenditures on showy headquarters and novel, sensational methods of treatment.

This constant expansion is sometimes instanced as proof of universal approval of previous provisions and of the general principle of sickness insurance. A closer examination of this development raises some questions as to the accuracy of these conclusions. It would scarcely be maintained that the continuous increase, almost from the beginning of the United States government, of the appropriations for "internal improvements" (the "pork barrel bills"), or of the similar increases in military pensions, indicates universal approval of all features of these systems.

In the case of insurance, just as with the examples from American legislation, a powerful organized minority, which in some insurance systems approaches a majority, has a great financial interest in pressing for extensions. The insurance carriers seek constantly to include a larger number of contributors with little regard to their material needs and utilize all their political influence to that end.

The most important line of evolution was one that again illustrates that a great increase in quantity usually means a change in the quality and characteristics of the phenomena. Sickness insurance started as a method of collecting and distributing cash benefits. Medical care was almost wholly incidental. The physician was called in, often asked and agreed to donate his services as a means of shortening the period of relief and, in case of suspected malingering, to give an opinion as to the seriousness of the sickness.

Gradually the medical side came to dominate all other features. But the administrative machinery and the attitude of the administrators underwent little change in some of their most important aspects. The expenditures for medical service are still looked on, if one is to judge by insurance society expressions, as primarily for their original purpose of protecting the financial resources of the carriers rather than the physical resources of the contributors. The physicians

are always considered almost entirely as sources of expense—sometimes it would seem as unnecessary expense—and the medical service as primarily for the purpose of policing the treasury of the society.

When, with the passage of years, this service came to be recognized as the most important feature of the whole system, and something that could be used effectively in securing new members, the carriers set out to expand it, but always with the attitudes just mentioned.

The system in each country usually started with coverage for industrial workers only and a medical service confined to home and office visits by a general practitioner. Then commercial, agricultural, domestic and other workers were included, the service was extended to their families and to specialist, laboratory, hospital, convalescent and every other form of medical care and service.<sup>13</sup> Tables 1 and 2 give the present extent of coverage and the principal items of service now furnished in the more important systems.

All the elements of this development were themselves changing as the years passed. Industrial and commercial evolution was impressing its pattern on the administrative side, so that the societies came to be more and more like the great financial, industrial and commercial establishments with which they were often closely connected. They sought to extend this pattern into the field of medical service and to erect medical service institutions resembling the factories and stores of the industrial system, with the physicians as employees.

The new discoveries and developments of medical science were hailed as analogous to mechanical inventions, offering new opportunities for "expanding the market" by emphasizing the "novel selling points" of the latest discoveries. The effects of this policy will be discussed later, but its importance to the whole story of sickness insurance and its origin as a part of the natural evolution of insurance institutions deserve mention here.<sup>14</sup>

It should not be assumed that there has been an identical development in all systems. Some of the later systems were more inclusive from the beginning and the British system, which was one of these, as to coverage but not as to services, has made few exten-

13. McCleary, G. F.: *National Health Insurance, 1932*, pp. 56-57.

14. Pick, Gottlieb: *Sozialversicherung und Aertzte, 1932*, pp. 13-16.



sions either of coverage or of services since its establishment. There is usually a maximum income limit, which is frequently raised in the course of years. In Austria, for example, the limit has been entirely removed for government employees, which has led to complaint by the physicians that many wealthy families now receive medical service from the insurance system.

Another line of evolution is from voluntary to compulsory. Every compulsory system has been preceded by a fairly extensive voluntary system. In the continental European countries these were either mutual labor societies, unions or plant industrial systems. In England almost every form of voluntary organization had been formed, and there had been a wide extension of all varieties of contract practice and public medical service.<sup>15</sup> These different schemes competed with one another and forced payment for physicians down to an unbearable level. Many physicians ran their own "private medical clubs" giving service for "a penny a week," out of which competition compelled them to employ solicitors. A large section of English physicians had been reduced to a desperate condition by these voluntary schemes before the compulsory law was proposed.

In view of later discussion to be given to the question of the relation of cash payments to the defects of sickness insurance, it should be noted that many of the English voluntary schemes, among some of which the medical abuses were worst, provided only medical care and made no provision for cash payments.

The evils within the medical relations of voluntary schemes varied in different countries. In Germany, Austria and Switzerland such schemes do not seem to have absorbed a sufficiently large section of medical practice, before the introduction of the compulsory system, to have had any important effect on the majority of practitioners. In France and the Scandinavian countries the organized medical profession seems to have been able to defend itself against the worst evils of the voluntary system.

Other undesirable features that developed with any lengthy duration and extensive expansion of the voluntary system have led to its abandonment for a legal compulsory scheme or else to the introduction of so

15. McCleary, G. F.: *National Health Insurance*, 1932, pp. 75-83.

many forms of direct and indirect compulsion that little of the voluntary phase, beyond the name, remains. Without some form of compulsion voluntary insurance fails of its objective of distributing the cost of sickness among large classes of the population with even approximate fairness. The young and healthy will not join and the aged and sickly, if accepted, will raise the cost to a prohibitive point and, if rejected, remove protection from those most in need.

(Sickness insurance cannot distribute the burden of sickness among the low income classes unless it is compulsory. Most of the so-called voluntary schemes have a large element of compulsion in them. This may take the form of making membership a condition of employment, or of membership in a labor organization, or even, as formerly in Denmark, to a certain degree a condition of citizenship. That all such indirect compulsion finally proves ineffective would seem to be indicated by the recent action in Denmark. This country, which has long been hailed by the defenders of the voluntary system as an example of successful operation without direct legal compulsion (although it exercised various forms of indirect compulsion so effectively as to include a larger percentage of the working class than most of the formally compulsory schemes) has adopted a thorough compulsory system, which went into effect Oct. 1, 1933.<sup>16</sup>)

One of the basic, though seldom mentioned, reasons why compulsion is necessary to effective operation is that sickness insurance is essentially a method by which the insurance management controls the expenditure of a part of the money paid out as wages, and such control requires compulsion. People do not willingly turn over to others the control of their incomes.

(Sickness insurance brings significant changes in the structure and operation of government. From another one of the many points of view from which it can properly be considered, it is a form of poor relief, the sources of which are obtained largely by taxing the low income classes.) One of the principal arguments constantly urged in favor of such insurance is that it will relieve other agencies of a large amount of the burden of poor relief. Yet in no country where sickness insurance has been introduced has it been possible

16. *Revue internationale, de Médecine Professionnelle et Sociale*, August 1933, p. 69.

to show statistically that the amount required for poor relief has fallen off as a result of sickness insurance. Although it seems possible that such a reduction might follow, the causes of indigence are so complex and the methods and extent of relief have changed so rapidly as to make any conclusions as to the effect of a single factor very difficult.<sup>17</sup>

The confusion of motives which sometimes considers sickness insurance as a method of relief for the semi-indigent, and at the same time as a method of distributing sickness burdens among the self-supporting, leads to further confusion.

The effect on the state itself of the great extension of welfare activities of a relief rather than, for instance, an educational character does fundamentally change the nature of government. It tends to shift the emphasis in legislation and administration from the organizing, directing, managing and protective functions to those of a dispenser of favors.

Social insurance and pensions are differentiated from nearly all other public or social expenditures in that their benefits are distributed to individuals according to their needs or special relation to the community. Police and fire protection, public hygiene, public works, education, and the like, are distributed *en masse* and, theoretically at least, benefit all equally. Cash and medical benefits under insurance, from their very nature, must be distributed unequally to individuals according to their personal need. They are, actually, a method of redistribution of national income to offset defects in the original distribution. (This is not offered as either a criticism or a commendation but only in explanation of the well recognized fact that such compulsory redistribution of income in a democratic government invariably becomes, in the hands of politicians, a method of purchasing votes with the accumulated funds, through political control of the distribution. These political effects are increased by the fact that no system of sickness insurance has ever been able adequately to meet the problem of combined financial and medical relief during sickness from the contributions of the insured. The first attempt to solve this problem is to enforce contributions from the employers, which is generally defended as being another method of

17. Eleventh Report, Ministry of Health, Great Britain, 1930, pp. 160-161, 175.

compensating the defects of an original distribution of income by compelling an increase of wages. However, the general consensus of economic opinion is that this method fails of its objective, as the employers' contributions are reflected in corresponding reductions in wages. It is otherwise maintained that such contributions are added to price and fall on consumers, which, if correctly explained, means that when sickness insurance covers a large share of the population, who are the consumers, the effect on actual wages is much the same.

While wages remain below a decent standard of living, the combined contributions of employees and employers must remain inadequate to the constantly increasing demands for benefits and resort is always had, in a greater or less degree, to subsidies drawn from taxation. This immediately carries the whole question of the amount and distribution of contributions and benefits into politics, with results already suggested, which will be discussed further in another connection.

When medical benefits come to occupy the most prominent place, these also become political issues, with harmful effects not only politically but on the service itself. Here it is not so much a question of the amount of the benefits as their control and the forms of supplying them.

Another effect of so extensive a scheme of state activity is the creation of a governmental bureaucracy, often duplicating in many respects that maintained by the insurance carriers. In Great Britain, where the collection and distribution of the contributions is assumed by the government (through the postoffice by a stamp system) and where every prescription (there are between 50,000,000 and 60,000,000 annually) is examined, priced and paid for through government offices, the extent and expense becomes very great. The total expenditures for administration in 1930 were £5,069,500 (about \$25,000,000 at par exchange) or 14.6 per cent of the cost of the scheme, of which the Approved Societies and insurance companies expended £4,109,900 and the Ministry of Health £959,600.

In deciding whether tendencies apparent in the older systems of Germany and Austria are destined to appear in more recently established systems, that is, whether these lines of development are typical and inherent in

the institution or are peculiar to those systems in which they have already made their appearance, it is necessary to consider to what extent the difference between earlier and later formed schemes is such as to prevent such developments. In the Danish, British and even more in the still younger French scheme, efforts of the medical associations have succeeded in procuring the installation of provisions intended to prevent domination of insurance carriers and to keep medical provisions under professional control.

It may be an indication that the forces of evolution here described need only time to enable them to overcome the defenses set up by the medical profession that the Danish voluntary system has already given way before the attacks of the societies and that the French Chamber of Deputies is even now considering legislation, backed by the societies, designed to destroy some of the provisions most highly valued by the French physicians.<sup>18</sup>

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## CHAPTER III

### MEDICAL SERVICE

Nearly every statement in regard to the working of sickness insurance is hotly disputed, but on no point is the evidence more conflicting than in regard to the character of the medical service. Propagandists for insurance grow enthusiastic in its praise, while opponents quote the frequently expressed German opinion that it is "always of the second class."

General judgments as to the character of the service in any country lose much of their value through the lack of any standards of comparison. The standard usually assumed, consciously or unconsciously, is that of conditions before insurance, and data are lacking on which to construct any other standard. Since there are no records available of the detailed and general character of the previous service, the comparison rests largely on the memories of those making the comparisons or on some specific point of change.

Another standard used is contemporaneous private practice in the same country. But a widespread system

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<sup>18</sup>. Cibré, P.: *Mutualization des assurances sociales*, Presse médicale, June 10, 1933, p. 636.

of insurance so limits private practice to classes economically different from the insured as to destroy much of the value of such comparisons.

These comparisons seldom attempt to measure in any way the great changes that have taken place in medical practice between the periods compared or to consider in what way the changes under insurance have differed from those in private practice in the same country or from the changes in countries without insurance.

Nevertheless such general opinions have a certain value as an introduction to any discussion of the effect of insurance systems on the character of the service given. A questionnaire concerning various features of sickness insurance was sent to the foreign correspondents of *The Journal A. M. A.* containing the following questions bearing upon the quality of the service:

1. Has the character of medical service been changed under sickness insurance?
2. Does the method of diagnosis under sickness insurance differ from that used in private practice?
3. Is there an increase or decrease of medication?

The replies from three countries, which are fairly typical samples of differing systems, are quoted. The Austrian correspondent said:

The insurance doctor with a fixed salary is apt to work more quickly but perhaps less carefully. He is less personal, more matter of fact and is perhaps not so deeply interested in the patient as a private patient expects.

Under pressure of work and stress of time the insurance doctor is much more willing to send a patient to the hospital if a diagnosis is not easily arrived at, or if it entails undue trouble. Otherwise the same methods are used.

There is a decided increase of medication; it is even encouraged by the insurance authorities, not only as regards the amount of remedies, the frequency of consultations and the number of ordinary calls, but also in regard to the kind of remedies and the method of prescription thereof. Ready-made medicaments, tablets, solutions and ointments are frequently prescribed or handed to the patients.

The reply from Great Britain was as follows:

Not to any great extent. However, some maintain that it tends to be more slipshod, while the insurance authorities say that in consequence of the assured income some men have established laboratories and are doing better work. While

accepting this, I think that there is a good deal of perfunctory work, especially at times of "rush," as during an influenza epidemic.

There has been a great increase of medication. The English have a great desire for and great faith in bottles of medicine, and, as medication costs them nothing under the panel, they indulge in it. The panel physician cannot refuse as much as he should, as he fears depletion of his list. An endeavor is made to check overprescribing by the panel committee, which can summon before them a physician whose prescribing is excessive and, if his explanation is not satisfactory, can fine him. It is noteworthy that the more intelligent Scotch have not such a desire for medicines and their panel drug bills are much less.

The Czechoslovakian correspondent replied:

The character of medical service has been profoundly changed in the direction of lower quality by the insurance practice. Naturally this affects more the class of medical service which deals with the working population where the fees are low and the system of fixed medical practitioners prevail than the system of insurance of clerks and officials where free choice of physician exists and where the fees are also higher. The medical service has become undoubtedly more superficial both among practitioners and medical specialists; on the other hand the volume of it has undoubtedly increased and has spread among those who have never benefited from it before when they had to pay for it from their own pocket.

The method of diagnosis among the lower classes of working population under the system of insurance is a very superficial one in general. In many instances it comes down to the diagnosis of the fact whether the patient is sick or not. In cities where consultation stations and clinics for specialist treatment exist, the patient is usually directed in case of a more serious sickness to the consultation service, where better facilities are available. In rural insurance funds the situation is more difficult and the hospital is the only place where the patient is directed in cases of doubtful diagnosis.

The method of remuneration plays also a rôle in this respect. In case that a physician is paid a fee per capita or per case of sickness he is more liable to direct the patients to the consultation service and specialist treatment in order to get rid of the complicated cases. In case that he is paid for individual visits he rather takes over the continued care of the patient himself. The general tendency toward the remuneration per case of sickness can be observed on account of difficulties connected with other forms of remuneration.

As a result of sickness insurance there has been an increase of medication; this applies both to drugs, medicines, medical appliances and physical therapy.

There have been numerous opinions expressed for propaganda purposes by the insurance societies and governmental bodies, which can usually be summed up by saying that "they looked on their own work and found it good." Instead of increasing this accumulation of contradictory generalizations it would seem that greater help toward more valuable conclusions can be given if the questions at issue are analyzed somewhat further into their various elements. The real question is not whether examples of good and bad service can be found under the various systems but whether the operation of insurance necessarily introduces elements that are detrimental or helpful to the maintenance of the best practicable medical standards.

The extent of the service given varies widely within the different systems and, in general, in obedience to the tendency to increase the scope of care as time passes, is usually most restricted in the more recent schemes. There are some exceptions to this rule, as are shown in table 2. Some of the more recent systems have adopted nearly all the present provisions of older plans.

This evolution and extension of medical care has been closely connected with and largely conditioned by the extraordinary medical progress of the last half century. This is not the place to tell the story of the advances that have been made during that period in every field of medical science and practice, of the achievements in research, the growth of specialism, the technical inventions, or of the expansion of hospitals and medical institutions that was largely an outgrowth of scientific progress. All these things led to a division of labor and a mechanization of certain sections of medical service, a development that was accelerated by similar developments in the industrial world.

These changes in medical practice came at the same time that the emphasis in sickness insurance was passing from financial to medical benefits and the whole system was coming more and more to be dominated by the medical service.

Sickness insurance was born when mechanistic theories of science were at their zenith and when the mechanization of industry was still hailed as an



unmixed blessing.<sup>19</sup> It was at a time when organization, division of labor, and standardization were the fundamental tenets of the gospel of social salvation. Medicine was hailed as having entered on this road through specialization and mechanization. It is not much of an exaggeration to say that the goal of medical service was seen to be a sort of glorified factory, with highly skilled physicians, diagnosing the raw material of patients with infallible mechanical laboratory accuracy and then passing them on with scientifically perfect production charts in the form of prognosis predictions and treatment instructions to the mechanized medical factories, where the necessary repairs and alterations would be made.<sup>20</sup>

The advocates of this new medical mechanization believed that such a scheme could be best operated by lay organizers and directors, who would be no more interested in the personal peculiarities, prejudices and emotions of individual patients and physicians than the factory managers of this period were in the same characteristics of their raw material, machines and employees. That this is far from being a caricature of the situation during the early period of sickness insurance or even of the attitude of many of those who are directing sickness insurance policies in Europe at the present time or are seeking to reorganize the medical service of the United States is shown by the statement already quoted of the official spokesman for the International Labor Office and many similar statements by politicians, welfare workers, sociologists and officials of sickness insurance carriers.

It was but natural that in such an atmosphere the new developments in medical science as organized in laboratories, clinics, hospitals, sanatoriums, and so on, should be taken over by the insurance societies unless provided by public authorities or other lay organizations.<sup>21</sup> It was not alone the financial support of these organizations that was assumed by the insurance

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19. Pick, Gottlieb: *Sozialversicherung und Aerzte*, 1931, p. 9. Faber, Knud: *Nosography in Modern Internal Medicine*, *Annals of Medical History* 4: 1-63 (No. 1) 1922.

20. Jauniaux, A.: *Cent Années de Mutualité en Belgique*, for advocacy of system of "polyclinics."

21. Pryll, Walter: Address at conference with the General Council of the International Association of Physicians, *Revue Internationale de Médecine Professionnelle et Sociale*, November 1932, pp. 113-119. Lehman, Helmut: *Aerzte und Krankenkassen*. Goldman and Grotjahn: *Benefits of German Sickness Insurance*, 1928.

societies of many countries, but also much of the medical control.

One result of following the industrial pattern was to exaggerate the importance of the administrative, managing, function at the expense of the actual medical function. The physicians were simply one group of employees along with the office staff and field workers, all under the control of the administrative officials, who assumed that they occupied an analogous position to that held by the owners of industrial plants. Even when the hospitals, laboratories and the like were publicly owned or built and maintained through philanthropy, their administrators talked and acted as if they were the owners. When these institutions were built from the contributions of the insured, the managers of the societies sought to enter into the position of owners and to treat the contributors as if they also were employees.

There were several results that followed from this situation.

1. The societies found these new and novel institutions with their somewhat mysterious and sometimes rather sensational processes and services easy to "sell" to the public. They were used as a form of "advertising leader" to attract members to the societies. They became the "talking points" which were stressed in intersociety competition.

When a system of sickness insurance is being advocated, great stress is laid on the value of the general medical service that is to be given to the contributors in their homes and the offices of the physicians. After a system is introduced, one may search in vain through all the voluminous reports and "selling literature" of the societies to find any praise of this service. All emphasis is laid on the institutions, owned, or at least controlled, by the societies, and the "additional benefits" that are organized and managed directly by the insurance carriers.

2. These conditions have led to an exaggeration of the value of the institutional services in comparison with the personal care of the physician, thus leading to a progressive mechanization of the medical service.<sup>22</sup>

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<sup>22</sup> Newsholme, Sir Arthur: *International Studies*, volume II, pp. 241-242. Helbich, Karl: *Aerzte und Sozialversicherung in der Tschechoslowakischen Republic*, Die Arztfrage, p. 161. Baeumer, Waldemar: *Die Krankenversicherung*, pp. 37-39.

3. These institutions became weapons of the societies in the fight to control the medical profession and reduce it to the position of employees hired, managed and directed by the societies. This not only tends to increase the disproportionate emphasis already placed on such institutions but makes it difficult to form any just appraisal of their value in a coordinated system of medical service. They became rivals of the physicians rather than instruments in their hands for the more perfect practice of medicine.

4. The erection and management of these institutions, under the conditions mentioned, led to wasteful expenditures of insurance contributions.

In the more recent systems of Great Britain and France the medical profession succeeded in prohibiting the carriers from entering into the business of building and conducting medical institutions, so that most of the evils proceeding directly from lay management of medical practice institutions have not arisen in those countries. One result of this restriction on the French societies, which limited their expenditures to medical services actually needed and which were supplied by personal attention of physicians and existing institutions, has been a rapid accumulation of funds in the society treasuries instead of the bankruptcy that threatens similar organizations in many other countries. Instead of suggesting a reduction of contributions to relieve their members or an improvement in medical care by physicians, these societies are using their political power to secure the removal of these building and extramedical activity restrictions and permission to build medical institutions and to offer such additional benefits as can be used to buy votes and control the medical profession.<sup>23</sup>

All of these developments tending to separate the administrative bureaucracy from the insured creates an attitude among the latter which has most far-reaching effects on the character of the medical service.

A British physician<sup>24</sup> says of this change:

The introduction of the industrial insurance societies into the national scheme altered the whole outlook of the insured persons. They have no interest whatever in the management of these societies; they think there is plenty of money to share,

23. *Presse médicale*, June 10, 1933, pp. 929-936.

24. Larking, Arthur E.: *Supplement to British Medical Journal*, Nov. 7, 1931, p. 266.

and they mean to get their portion. The agents of these societies are often inclined to favor the insured person rather than the funds of their society. They point out to them the advantage of insurance in their society at the same time. People who ten years ago would hesitate about accepting sick pay unless they were really very ill nowadays get all they can and stay on as long as possible. I wonder the sick claims are not more.

The medical care is supposed to be given in case of sickness. The whole scheme centers around the phenomena of sickness. It is impossible to go far in discussing the medical service without meeting the question of the sort of sickness that is treated, because that sickness presents many characteristics not encountered in private practice. But no one has yet found a satisfactory definition of sickness which will fit into the conceptions of insurance administration.

There is the sickness which entitles the members to financial relief, a condition which is defined as a state of inability to work. This will be further discussed when the effect of insurance on the medical profession is considered. Suffice it to say here that the diagnosis of the type of illness just mentioned assumes the qualifications of a detective and a criminal investigation department as well as those of a physician. Three important phases of this condition especially affect the character of the treatment of the mass of patients: First, the dual attitude of policeman and physician introduces an atmosphere of hostility and suspicion into the relation of patient and practitioner and makes diagnosis and treatment difficult and unsatisfactory. Second, the great amount of time required for the police work often makes proper attention to legitimate medical work impossible. Third, as will be shown in greater detail later, insurance itself creates a considerable amount of sickness, in the form of neuroses, and prevents their proper treatment.

The greed to get "something back" encourages a flood of patients with such minor illnesses as to have no real need of medical service. These are the "bagatelle cases" on which such a mass of discussion has centered in the German system and which tend to multiply with the passage of time in every system in which the responsibility for payment for medical service bears no relation to the individual need for such service. Numerous German students now estimate that from

60 to 75 per cent of the time of insurance physicians is consumed in handling cases in which their services are of no particular value to the patient.

The worst side of this situation is not the waste of time and money on such patients, nor even the tendency to create a horde of neurasthenics and prescription addicts, but rather the fact that this condition prevents any adequate attention and proper treatment of those to whom medical service is of most vital importance and value. This neglect of the really sick arises not only from the absolute lack of time of a physician whose office is crowded by those who come only for written certificates of inability to work or to "get something back" in the way of attention and medicine, but, perhaps even more, from the inevitable tendency of such a situation to create an attitude of indifference and suspicion on the part of the physician. After examining nine persons who have no need of his services, it would take most exceptional scientific control to approach the tenth without a presupposition that he also wanted nothing more than a "look and a bottle."<sup>25</sup>

That many students of insurance systems testify to finding some physicians who seem to possess such a genius for diagnosis and such high scientific and professional ideals as to have considerable success in rapidly sorting out these superfluous applicants for care in order to devote their attention to those whom they can truly serve is more of a tribute to individual personality and integrity than to the workings of the system. Even under the best of conditions there is a tendency for the emphasis in medical care under insurance to be shifted from the catastrophic cases or incipient diseases in which the individual need of help is greatest to minor diseases in which the burden is slight and medical care is of least value.

Any discussion of medical service under insurance must return again and again to the question of just what is treated by the physician. In private practice it is a person with some pathologic disturbance of normal organs or functions. Under insurance this disturbance, called sickness, is, in a vast number of cases, more economic than pathologic. Perhaps it would be closer to scientific accuracy to say that whatever pathologic phenomena exist in these cases are caused by economic

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25. Winands: Zentralblatt für Reichsversicherung und Reichsversorgung, June 1930, p. 200 et seq.

Morbidity Rate

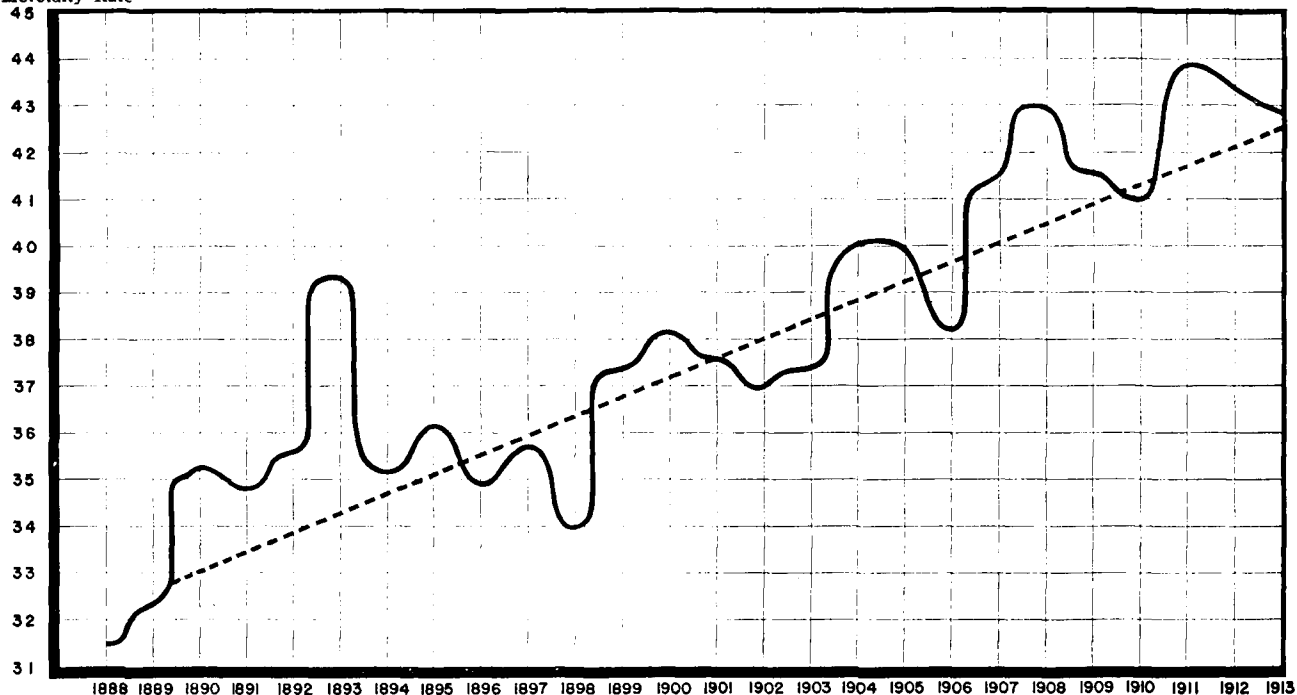


Chart 1.—Morbidity in German local insurance societies (Ortskrankenkassen): Solid line is smoothed curve of actual morbidity rates as measured by certified cases of incapacity for work; the trend line is dotted.

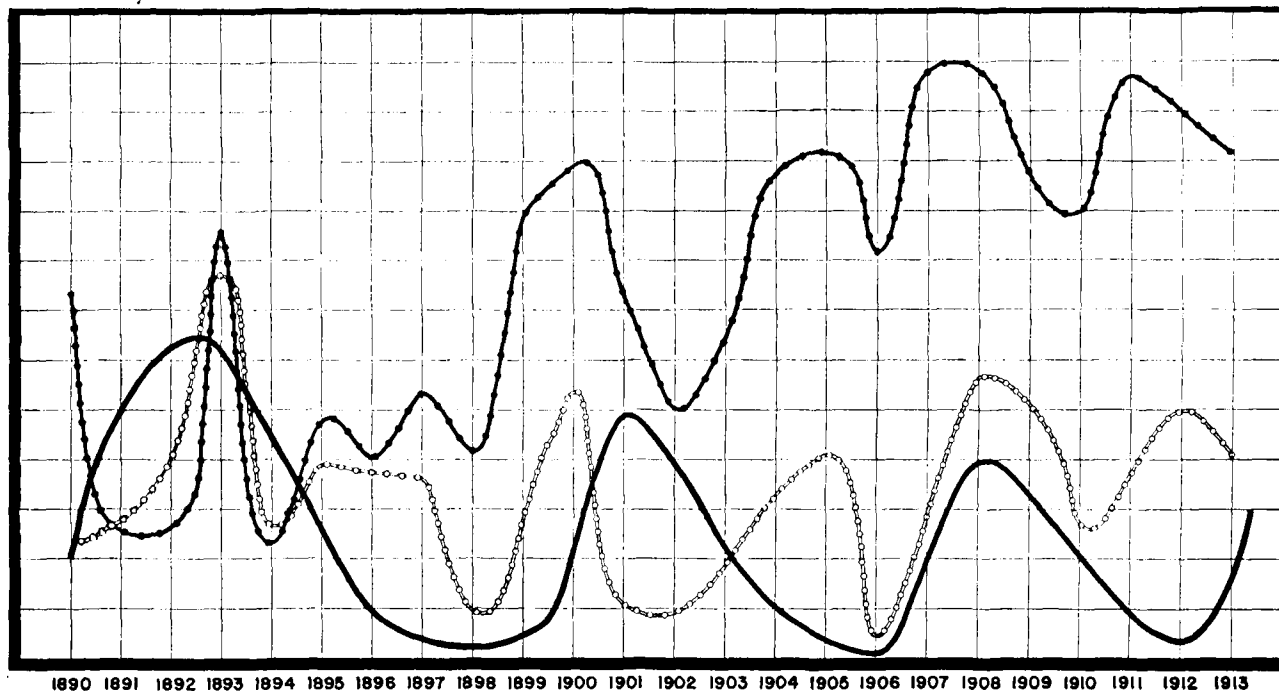


Chart 2.—Morbidity and business conditions, 1890-1913: Solid line shows depressions and prosperity in reverse, with crises at high and prosperity at low points; lower open line with circles shows sickness record of Pommeranian local societies (Ortskrankenkassen); upper line with solid dots, of industrial societies (Betriebskrankenkassen).

conditions and require economic or social rather than medical treatment.

This confusion of economic and pathologic factors runs through most of the discussions of organized medical care, making much of the data used, and practically all of the conclusions based on that data, false and foolish. Sickness is not identical with inability to work, with days lost from employment, with expenditures for drugs or medical care. The attempt to measure sickness by any of these things, without first calculating the mathematical correlation between them and pathologic conditions (something that is never done and probably is impossible) only leads to ridiculous errors.<sup>26</sup>

Nevertheless practically all the "morbidity" statistics supplied by insurance systems involve just this confusion. The most common measure of sickness under insurance is the number of days for which the insurance carrier paid benefit because of incapacity for labor. The first conclusion which a study of these statistics would justify is that insurance seems to be some sort of deadly infection, the introduction of which causes a constantly increasing amount of sickness.

The German system has existed sufficiently long to demonstrate this typical trend. Chart 1, taken from Werner Lincke, "Krankenstand und Arbeitswille," page 38, shows the fluctuations of this sort of "morbidity" from 1888 to 1913. The sudden upward movements of the line do not indicate deadly epidemics of disease, so often as some sort of industrial change. This is shown by chart 2, taken from the same source (p. 154), where the same kind of "morbidity" in two of the largest societies is plotted in comparison with a line showing the cyclic movements of industry during the same period.

When shorter periods of fluctuations are concerned, it is often possible to trace effects of influenza and other disease epidemics,<sup>27</sup> but more violent and far more frequent short fluctuations are produced by strikes, lockouts, variations in the form of wage payments and other industrial events.<sup>28</sup>

26. The unreliability of all morbidity statistics under insurance is discussed by Beyrodt, Gustav: Die versicherungswissenschaftlichen Grundlagen der Sozialversicherung, Archiv für Soziale Hygiene und Demographie, September, 1932, p. 345.

27. Report of Arbeiterkrankenversicherungskasse, Vienna, 1931, p. 5.

28. Linke, Werner: Krankenstand und Arbeitswille, 1930, pp. 82-113.



All of these conditions have been increased by the exceptional economic conditions that have prevailed in Germany since the war. Perhaps the most startling proof of the character of the "sickness" treated by insurance was offered by the effects of inflation. In 1923 the money given as cash benefits was so nearly valueless that it was not worth while being "sick" to get it. As a result, the number of days of "sickness" as measured by "inability to work" fell off over 100,000,000, or about 50 per cent.<sup>29</sup>

Meanwhile the physicians continued their work of caring for the insured, receiving their pay in money that had lost practically all purchasing value. "From the autumn of 1922 until the end of 1923 almost the entire medical profession of Germany carried on their insurance practice for practically worthless payment."<sup>30</sup>

Erwin Liek,<sup>31</sup> the well known critic of German sickness insurance, gives further specific details of this side of the subject:

It is highly significant that the frequency and duration of sickness increase steadily under insurance, although one would naturally expect the reverse. That holds true not only for Germany but for all countries that have introduced sickness insurance. It must therefore be recognized as a law by which to measure developments. With us conditions have reached the stage where every insured person is sick twice a year. Every second insured person is sick to the point of incapacity for work. Weber (director of the Union of Krankenkassen of Aix la Chapelle) recently stated that in his jurisdiction in 1928 only 65 out of 1,000 insured had not asked assistance of the Krankenkassen. Of the other 935, all had asked at least once. Weber brought out two other facts:

(a) "Thirty-five million insured pay four times as much for medical costs as thirty million not insured."

(b) "The Imperial Health Office stated at its meeting, Sept. 7, 1924, that the insured patient uses three times as much medicine as a private patient. Since that time the cost of medicine has still further greatly increased."

Very well informed and careful bookkeeping physicians have given me quite different figures. They estimate the amount of sickness of the uninsured at 20 per cent yearly, while among the insured it reaches 200 per cent.

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29. Baeumer, Waldemar: Die Krankenversicherung, jetzt ein Fluch, umgestaltet ein Segen für das Volk, 1930, p. 40.

30. Lennhoff, Rudolph, and Finkenrath, Kurt: Das Verhältnis zwischen den Krankenkassen und Aerzten in Deutschland, Die Arztfrage, p. 24.

31. Liek, Erwin: Soziale Versicherungen und Volksgesundheit, 1929, p. 20.

I will go a step further and say that every new insurance, every new institution for charitable care, means a new source of sickness for our people.

Another almost equally startling illustration of the character of the "sickness" that must be treated by insurance physicians was given when the "emergency decree" in 1930 required the payment of 12 cents for the first consultation in any case. "Sickness" once more fell off about 50 per cent in a number of German cities.

It is often claimed that the increase in "morbidity" rates in recent years is due to the increase in the average age of the insured, which has followed the greatly

TABLE 4.—*German Morbidity: Group by Years, 30-39 Years\**

Sex	Year	Krankenkasse	One Death per		Instance of Sickness According to	
			Cases of Sickness	Days of Sickness	Cases of Sickness	Days of Sickness
Men	1887-1905	O. K. K. Leipzig	53.10	1,220.21	0.438	10.01
	1928-1930	Leipzig Stadt	130.84		0.572	
	1928-1930	Leipzig Land	156.31	4,426.88	0.683	19.35
Women	1887-1905	O. K. K. Leipzig	71.46	2,130.24	0.565	16.85
	1928-1930	Leipzig Stadt	125.37		0.570	
	1928-1930	Leipzig Land	145.00	4,705.67	0.660	21.41

\* Gustav Beyrodt, Leipzig, "Die versicherungswissenschaftlichen Grundlagen der Sozialversicherung," in *Archiv für Soziale Hygiene und Demographie* 7: 346 (Sept.) 1932.

increased average longevity, caused in all modern countries by the progress in medical science and the application of the fruits of that science through public health measures and preventive medicine. But the same tendencies are shown among those in the prime of life, as table 4 shows.

While this increase in "morbidity rates" under insurance is closely related to the desire to obtain cash benefits, yet this is by no means the only cause. The same tendency is found among dependents of insured who are not entitled to cash benefits. Kurt Finkenrath<sup>32</sup> made a study of the "sickness" statistics of two Austrian societies and found that there was an even more rapid rate of increase in the "morbidity rate" among

32. Finkenrath, Kurt: *Aus der Krankenversicherung in Oesterreich*, *Deutsche medizinische Wochenschrift*, Aug. 8, 1930, p. 1356.

dependents who receive no cash benefits. He concludes that this increase, with the accompanying waste of insurance resources, is due to the excessive demand of the insured for unnecessary service. This is especially seen in the abnormal increase in such services as quartz lamp treatments (more than fourfold in seven years)

TABLE 5.—*Medical Services in Krankenkassen, Steiermark and Kärnten, Graz, Austria*

Year	Average Membership	Number of Cases Treated	Per Cent of Members Sick	Certified as Sick	Per Cent Certified	Cases of Dependents Treated	Per Cent Dependent to Members' Treatment
1918	36,584	49,756	136.0	30,523	61.35	7,676	15.42
1919	39,624	43,839	110.7	21,837	49.18	9,309	21.44
1920	46,340	54,725	118.0	28,999	52.99	14,441	26.39
1921	46,608	58,446	125.4	30,376	51.97	17,438	29.83
1922	45,500	64,521	141.8	31,640	49.04	19,918	30.87
1923	40,014	64,661	161.6	27,744	42.90	22,804	35.26
1924	40,931	69,534	170.0	31,404	45.18	24,367	35.04
1925	38,737	71,516	184.6	31,119	43.52	26,392	36.10
1926	39,323	74,430	189.0	31,133	41.82	27,762	37.30
1927	39,251	74,678	190.3	31,443	42.10	27,212	36.44

and of roentgen treatments that multiplied almost twenty times in the same period.

Because, as Dr. Finkenrath states, this is almost the only time that any large insurance practice has been

TABLE 6.—*Infant Mortality in Prussia*

	1913	1925	1926	1927	1928	1929
Among the wealthy .....	6.5	4.1	4.1	3.6	3.4	3.4
In the middle class.....	8.9	6.5	6.4	6.4	5.9	6.6
In the working class, excluding those occupations in which there are a large number of illegitimate children .....	14.1	10.4	10.1	9.7	9.4	10.8
Working class, including occupations with many illegitimate children .....	21.4	15.6	14.9	11.2	12.5	13.5

analyzed in this manner, the complete tabulation of his results is given (table 5).

A side-light is thrown on this question of the effect of insurance service on general health by table 6, of infant mortality in Prussia:<sup>33</sup>

33. Hofbauer, Albert (vertrauensarzt): Der gegenwärtigen Standpunkt der Krankenkassen zur Sozialhygiene und Gesundheitsfürsorge, *Zeitschrift für Gesundheitsverwaltung und Gesundheitsfürsorge*, Feb. 20, 1932, p. 7.

As practically the entire working class in Prussia has been under an insurance system that supplied supposedly unlimited medical care to entire families, this would seem to offer a fair comparison between those so cared for and those who are largely in the care of private practitioners. Perhaps the most significant feature of these figures is not the somewhat startling fact that infant mortality in even the most favorable section of the working class is nearly three times as high as among the wealthy and nearly 50 per cent higher than in middle class families. Similar correlations have been found between infant mortality and income in the United States, but the results shown in the series of years, might, however, raise a doubt as to whether the introduction of sickness insurance would reduce that rate among the insured. It is far more significant that, although the insured population at the earliest period had a much higher rate of infant mortality, and therefore offered far greater opportunities for a striking reduction, the table above shows that the rate of decline was far less rapid among the insured class.

The German system has been used to illustrate these conditions because it is the only one, except that of Austria, where, as the facts just cited show, identical developments are found, that has existed sufficiently long for the effects to become fully apparent.

Similar tendencies are developing and causing concern in every other system. In England, "while 14 out of every 100 claimed sickness benefit in 1921, the proportion had grown to 23 in 1927. Among unmarried women the respective proportions were 12 and 21, and among married women 19 and 38. The growth in the intervening years, though not regular, was practically continuous."<sup>34</sup> The same report concludes that "the chief conclusion to be drawn from the foregoing tables is that there has been a continuous growth in the number of insured persons claiming benefit and that this increase is most pronounced, on the whole, in the claims of short duration."<sup>35</sup>

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34. Report by the Government Actuary, 1930, p. 8. See also Report, 1931, summarized in the *Lancet*, Dec. 26, 1931, pp. 1423-1424. Oliver, Sir Thomas: *Journal of State Medicine*, August 1930, pp. 455-463. Davies, Walter: Presidential Address on A Coming of Age: Promise and Performance, *Journal Royal Sanitary Institute*, October 1933, pp. 219-221.

35. Report by the Government Actuary, 1930, p. 14.

Such "morbidity" presents strange phenomena. In England, for example, we learn that:<sup>36</sup>

The case of domestic servants is particularly interesting, for here the improvement in working conditions is universal, yet this is coincident with a steadily growing number of claims on the part of domestic workers for sickness benefit. When the Insurance Act was first passed, the health of domestic servants was so good that they wished to be insured in a special unit so as to obtain extra advantages to which their low sickness rate seemed to entitle them. Now it is found that they are becoming a heavy burden on the insurance funds, and it is difficult to discover why their health should show this backward tendency.

It is certainly difficult to account for such a tendency by anything except the influence of insurance in cultivating the desire to "get something back" in return for the contributions. This was a period when death rates were steadily falling, when many diseases were being reduced in virulence and when, without any doubt, actual pathologic conditions in the mass of the insured, at least, were growing less. But insurance creates much of its own morbidity.

[Variations as to "morbidity" statistics between systems can much more frequently be traced to differences in the law or in economic conditions than to variations in actual health conditions. It takes an average of a week longer for a broken leg or a dislocated shoulder to heal in Germany than in Switzerland, but the explanation is not found in the greater salubrity of the Swiss mountain air or the exceptional skill of Swiss surgeons but in the different rates of disability pay.]

It requires at least a generation to eliminate the old sense of personal responsibility and fraternal integrity that prevailed before compulsory insurance, and to develop the "greediness," the feeling that enforced contributions have created a "right" to cash and service, which should be exercised, and that the insurance funds belong to the contributors, who are therefore entitled to get all they can out of them, by whatever means may be most effective.

The older insurance physicians testify that in the early days of insurance the members were economical of drugs and the services of the physician but that the younger, more recent, members are always trying to

36. Milnes, Nora: Aspects of British Health Insurance, Social Service Review, December 1932, p. 587.

get their "money's worth."<sup>37</sup> They demand expensive advertised drugs and if they are told that they have no need of a prescription they become insulted, believing that they are being accused of malingering.

It was formerly assumed that the phenomena described were due to conscious malingering and attempted fraud. Therefore the efforts to control these developments were directed toward multiplying and strengthening the police functions of the physicians and supplementing these with stricter regulations. Without raising the question of the justification of a system that collects compulsory contributions to police the contributors (and in most systems of insurance a considerable portion of the contributions must be used for this purpose to avoid bankruptcy), experience, as illustrated by the facts just given, has only served to prove the futility of such measures.

The physicians who are the only ones in a position to get the facts, and the only ones competent to judge them, seem to agree on a wholly different interpretation of the situation. The same physicians who estimate that from 60 to 75 per cent of those who come for medical service are in no condition of sickness to derive any special benefit from such services also agree that not more than 5 per cent of insurance patients are conscious malingerers and that these do not present the greatest problems in medical treatment.

The most serious phase of the situation is that insurance itself creates a vast amount of genuine sickness. The very word "neurosis" came into the medical vocabulary with insurance, and for a long time the existence of any condition that could properly be described by that name was denied by many physicians in noninsurance countries. Psychiatrists now recognize that neuroses are not confined to insurance cases, but it still remains true that insurance is responsible for a greater number of such cases than any other single cause.

Dr. Victor von Weizsacker, head of the psychiatric clinic of the University of Heidelberg (the oldest clinic of the kind in the world), has for several years been studying this problem and has come to the conclusion that a large share of all the sicknesses treated under insurance are complicated by neuroses for which the

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37. Baeumer: *Die Krankenversicherung*, pp. 52-54.

situations and conflicts created by insurance are largely responsible, while many sicknesses are due wholly to such neuroses.<sup>38</sup>

E. Blum,<sup>39</sup> a psychiatrist of Bern, Switzerland, has analyzed this entire situation in a most striking and convincing manner. He points out that sickness returns the adult to the attitude of a child in which he is ready to receive care without any reciprocal action on his part. "The effort toward adjustment to reality," he says, "is replaced by the desire for indulgence, nursing and maintenance of the infantile situation. So we arrive at the remarkable fact that the sick seek to gain pleasure and profit from the condition of sickness and, in spite of their sufferings and burdens, basically do not wish to get well. So we speak of a *flight* to sickness and of a sickness advantage (Krankheitsgewinn).

Dr. Blum continues his analysis and its relation to present economic conditions:

The majority of mankind are in a hard struggle for existence. Sickness grants them an opportunity to escape from this. Monotonous occupations, enslaving factory labor, can be interrupted. Labor is not only exhausting but rushing and depressing. Adaptation to the dictated rhythm of the machine, to the noise and unsatisfactory conditions during labor, demands continuous self control and conquest of disagreeable feelings. It is understandable that sickness or accident means a period of rest and release that is not willingly given up, and during which the health conscience slumbers.

Dr. Blum explains that in modern society this situation is further complicated and aggravated by a conflict between the individual and society. Sickness increases the individualistic feeling and weakens the sense of social responsibility. He points out the effect of insurance on this condition in the following conclusion:

So there is created out of this at first perhaps latent, slumbering situation of conflict a wholly characteristic reaction to the very fact of the existence of insurance. Insurance sets up a social institution in which the individual pays his regular contributions or tribute, of the individual to the good of the

38. Soziale Krankheit und Soziale Gesundheit, 1930, pp. 8-9 et passim. Ueber den Begriff der Arbeitsfähigkeiten, Deutsche medizinische Wochenschrift, Sept. 25 and Oct. 2, 1931, pp. 1653-1657 and 1696-1698; Erwin Liek (Soziale Versicherungen und Volksgesundheit, p. 20) says: "Every new insurance . . . means a new source of sickness for our people." Pick, Gottlieb: Sozialversicherung und Arzt, 1931, pp. 13-29.

39. Blum, E.: Gesundheitsgewissen und Sozialversicherung, Schweizerische Zeitschrift für Hygiene, July and August 1931, pp. 733-750. Italics in original. Fisher, V. E.: Introduction to Abnormal Psychology, 1929, pp. 174-175.

community, in order later to draw these out for the benefit of the individual. This sacrifice to the good of the community arouses the thought of the possibility of a later "*revanche*," of a demand of the repayment of a debt. . . . This finds full and complete expression in the sick person. We have already seen that sickness isolates, separates the individual from the community and develops egoistic special interests and so creates an antagonism in the social order. For the injustice that has befallen him through no fault of his own he demands from society (social insurance) restoration and indemnity.

. . . .  
 All these previously described phenomena are increased by the existence of insurance. The infantile situation already created by sickness is strengthened. Just as the child from the parents, so the sick demands from *insurance* protection and indemnity for the wrong he has suffered. . . . The struggle for health appears senseless to him. . . .

*So we arrive at the tragic fact that an institution created in response to the highest social impulses and to serve such social purposes encourages the antisocial attitude (asocialität) of the sick, undermines the desire for recovery and endangers health.*

These are the "sicknesses" to which the insurance physician must devote a large portion of his time and energies. He must, except in the English and French systems, look to the insurance carriers for his payment, and these constantly remind him that he "who pays the fiddler calls the tune." Even if the carriers were fitted to supervise a medical service, which the laws of every nation affirm they are incompetent to practice, their objective is not improved diagnosis and treatment of the patients' physical ills but rather of their own financial troubles. It is true they will spend vast sums on laboratories, baths, radiant treatments, clinics, convalescent homes and so on, often far more than the interest of good service to the patient demands; but they will rally all their powerful forces to fight any move for such adequate payment to the physicians as would permit proper application of time and skill at the point where it is most essential—when patient and practitioner are in personal contact. There is no glory, profit or advertising and no political advantage to be gained by the societies in paying more to physicians. On the contrary, the credit for results produced through individual medical care would go to the physicians and not the insurance carriers. The effect of this situation in determining the expenditures of the



carriers, while they are engaged in a bitter feud with the physicians, scarcely needs explanation.

The patient knows that a part of the duties of the physician is to police the society treasury against often unjustified demands. The patient comes often to secure proof that he is sick rather than to obtain treatment for his illness. The resulting atmosphere of suspicion, hostility and matching of wits is the worst possible one in which to conduct an accurate diagnosis and to apply successful treatment.

The patient knows of restrictions on prescribing, and if he does not receive the latest highly advertised and expensive drugs or the most sensational and fashionable treatment with costly x-ray or other machines he believes it is not because these are unnecessary but because the society's orders for economy prevent their use in his case. An experienced insurance physician<sup>40</sup> describes the situation thus:

Hundreds of times, sometimes from the seriously sick, more often from the neurasthenic, have I been begged in mortal anxiety to prescribe something good, for which they would gladly pay. Consider the misfortune of these poor beings who believe themselves candidates for death, who must stand constantly in the shadow of death, just because they are insurance patients! Whenever I have met with such a situation, I wished I had the legislator within reach, in order to physically vent my rage on him, because he, in order to rescue a throne, brought this evil on a people.

The insurance patients who make such requests are the quiet, intelligent minority. The majority choose other, more violent, methods. They simply demand, and the physician who does not grant their demands soon finds his consultation room empty. I knew only one such physician, whose excessively ideal conception of his profession would not permit him to make any concessions to the public—a physician such as the Krankenkassen desire. The result was that, although his children are still at home, his wife must do home work for a manufacturer. According to my opinion and that of many others who are not physicians, this physician should have a guardian. His efforts have not even resulted in economy; their only effect has been that he is impoverished, while his patients went to other physicians, after first visiting him and thereby creating new medical costs, in order to get what they wanted, and the kasse paid the cost. . . .

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40. Baecmer: *Die Krankenversicherung*, pp. 32 and 78. Newsholme: *International Studies*, vol. II, 1931, p. 222.

Every week members of the Krankenkassen come to me and wish to pay their own charges because, in their desperation, they believe this is the only way they can get a good diagnosis and treatment. Those physicians who have no insurance practice receive many more such. At least half their patients have already been treated by the insurance physician at the expense of the kasse but mistrust the insurance physician and think these are afraid to spend money. They pay twice for their sickness, once to the Krankenkassen and again for the physician of their choice.

The most severe criticism of medical service under insurance is not based on the occasional examples of overworked practitioners, with resulting hasty careless diagnosis and treatment, but rather on the atmosphere of suspicion and antagonism, which destroys the very foundations of good service. Payment into a general fund over which the insured has no control (and from which he can get back his money, to which, rightly or wrongly, he believes he is entitled) only by being sick, creates the conditions described.

It is not true that these conditions prevail to the same extent in all systems of insurance. They are much less evident in the English, French and Scandinavian systems, in which the control of medical practice remains largely in the hands of professional associations. They arise largely because of the combination of cash and service benefits in the same system, and even more from this domination of a "third party," the insurance carrier, as administrator of the scheme. These conditions are also partly due to the fact that in nearly all insurance schemes the individual contributor is relieved of all immediate personal financial responsibility. Up to the present time no nation has experimented with any plan in which all of these features were absent, and it is therefore impossible to do more than theorize on the question of whether their removal would abolish these defects in insurance medical service.

## CHAPTER IV

### THE PHYSICIAN IN SICKNESS INSURANCE

At the time of the introduction of the first sickness insurance systems, physicians were usually favorable to their development. Later, painful experience caused them to become critical and hostile to many phases of insurance although at no time, in any country having

such a system, has the organized medical profession opposed the principle of insurance as a method of providing medical care for the underpaid.

An Austrian physician, with long experience in various phases of sickness insurance, says that when the officials of the various European and some non-European medical associations met in Paris in July 1926, the one thing for which they were all seeking, and seeking in vain, was a system of insurance that gave any consideration to the proper interests of the physician.<sup>41</sup>

Conditions were often more satisfactory in the beginning, but as the influence of lay organizations increased, the attitude of the insured changed and political considerations entered, it was almost inevitable that the tendency toward industrialization and commercialization should increase with the consequent lay domination of the medical profession, destruction of professional ideals and deterioration of the medical service. Those who were active in the political and economic phases of insurance were so confident of the correctness of their own conclusions that they seldom stopped to consider the effects of building a medical service based on the compulsory destruction of the independence and ideals of those who must deliver that service.

The history of the attitude of the physicians to the establishment and development of the Austrian system, and of that branch which continued in Czechoslovakia, is thus described by Dr. Karl Helbich<sup>42</sup> of the latter country:

Just as soon as any of us speak of the relation of physicians to social insurance, a picture of two fighters arises: physicians and *krankenkassen*. Their continuous conflicts during the last twenty years have created a sort of subconscious feeling that these two must be enemies. The *krankenkassen*—perhaps sincerely—have cultivated the subconscious idea that this condition exists because the physicians oppose social insurance for selfish reasons.

But when what is now the most important branch of social insurance—sickness insurance—was introduced in 1888 the

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41. Stritzko, Joseph: *Die Aerzte Oesterreichs und die Sozialversicherung, Die Arztfrage*, 1926, p. 108.

42. *Arzte und Sozialversicherung in der Tschechoslowakischen Republik, Die Arztfrage*, 1926, pp. 159-160. The story of a similar evolution in Austria is told by Narbeshuber, Carl: *Les chômeurs des médecins en Autriche, Revue Internationale*, February 1933, pp. 57-66. The societies' side of the story is given by Lehman, Helmut: *Aerzte und Krankenkassen*, 1929, pp. 8-9.

kassen did not find the physicians in any way antagonistic. No one can cite a single antagonistic expression from the physicians at this time, while on the contrary it would be easy to cite many cases where their highly valued services were given to the new institutions out of benevolence and humanity. By and large, however, physicians have not been attracted by the later developments. In addition to ignorance of the significance and effects of insurance, which no one could rightly value at that time, a further cause of this attitude was that the physicians had no real professional consciousness, and consequently no professional organization, both of which really were first aroused to life by sickness insurance. . . .

The conflict which soon arose and sharpened out of the original antagonism between physicians and krankenkassen had its origin in different conceptions of the purpose of sickness insurance. While the physicians saw in it an opportunity for what later came to be known as "public health care," the krankenkassen were interested in the financial benefits.

Since the krankenkassen controlled the financial resources they were able to direct the development of sickness insurance according to their ideas, without worrying about the medical ideas. The latter penetrated very slowly and only began to receive consideration after four decades, as being in any way as important as the ideas of the kassen.

According to the view of the physicians, the purposes of sickness insurance should rank in the following order:

1. To help restore the lost capacity for labor.
2. To protect the capacity for labor.
3. To assist the insured to maintain his standard of living.

Theoretically the correctness of this medical classification of the purposes of sickness insurance is today universally recognized, but its practical application is widely opposed.

There is a similar story of early medical support for insurance, followed by disillusionment of the medical profession as the objectives changed in Switzerland.<sup>43</sup>

It must also be remembered that the physicians welcomed the introduction of sickness insurance from an idealistic and materialistic point of view; so it was that we actually found that the most enthusiastic supporters in the early years were many physicians and whole medical organizations.

On the other side there soon arose certain antagonisms between the kassen and the physicians so that today very few physicians as such, but only as members of political parties, are found among the proponents for extension of sickness insurance as it exists at present. . . .

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43. Leuch, O., Jr.: Die Arztfrage, p. 141.

The effect of changing the objective of sickness insurance from a scheme of financial relief to that of a medical service, while its administrative machinery and methods remained unaltered, was to vest the conduct of a compulsory, and often almost universal, health and medical service in the hands of a lay organization totally unfitted for any such function. These carriers had now become too powerful, financially and politically, to be dislodged. They had secured the backing of their army of employees, of most of the employers, of the unions and of the various national labor parties.

Through these supporters, from whom the representatives are elected to the International Labor Conference, the governing body of the International Labor Office, they were able to dictate the policies of that organization. This resulted in the adoption of resolutions urging all affiliated nations to adopt systems of compulsory sickness insurance, based on a plan which vested control in the carriers. This made the International Labor Office a propagandist not simply for insurance but for the particular kind of insurance desired by the carriers and which gave the carriers control of the medical service.<sup>44</sup>

There were no physicians officially represented at any of the discussions of sickness insurance policy by this international body. Only after much protesting and petitioning was a committee of physicians admitted in a purely consultative policy to meet with representatives of the International Labor Office. At this meeting the representatives of the office took occasion to lecture the physicians and to defend the policies of the insurance societies. These facts are especially significant in view of the tendency to look on the extensive publications of the International Labor Office as impartial research documents on sickness insurance.

These publications have become the most important source of material in support of sickness insurance. They are a most misleading source. It is not so much that facts are misstated or even misinterpreted, although examples of these may be found, as that all reference to undesirable features are omitted or belittled and the impression is given that all systems are satisfactory, an

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44. *Revue Internationale de Médecine Professionnelle et Sociale*, November 1932, pp. 109-113, and February 1933, pp. 3-6. Report 10th Session International Labor Conference, 1927. *Jahrbuch der Krankenversicherung*, 1930, p. 168.

impression that is certainly false. The same attitude is maintained by most of the advocates of insurance in the United States.

The physicians, in most European systems, were caught up in an ever increasingly powerful social organization in the creation or management of which they had almost no share. As this system extended, its first effect was apparently to increase the demand for medical services. The societies encouraged this tendency in order to secure a surplus of physicians, whose competition would force down payments. It would not be fair to exaggerate the effect of insurance as a cause of the increased attendance at medical schools. It is true that most medical writers in countries with insurance systems give this as one of the principal causes, but it is also true that a similar increase occurred in nations without insurance. The undisputed fact is that the existence of this surplus of physicians worked to the advantage of the funds in the struggle to control the medical profession.

All the phases of this conflict, which rages in nearly every country, between physicians and carriers are but different aspects of the question of lay control of medical practice which is inherent in the form of organization and evolution of sickness insurance. The efforts of the societies are everywhere directed against destroying the professional status and substituting the industrial contract relation. It is the universal opinion, not only of the medical but of all other professions, that such action destroys much of the value of professional service. Experience in sickness insurance would seem to justify this opinion.

A fundamental issue in this struggle for professional status is the question of the free choice of physician by the patient. In the commercial market the purchaser has almost no choice as to who shall produce the goods that satisfy his needs and, with the progress of standardization, no wide choice of the special character of the goods that he will purchase. In industry the employer is the one that exercises the choice as to the employees who are to produce the goods to be sold to the consumer.

The employer owns the goods produced and has the function of marketing them. He seeks, through salesmanship, to secure the choice of his goods by the buyer

among all goods offered on the market. The buyer has been taught that he must "beware" in dealing with the seller. He is supposed (often contrary to fact) to be able to judge of the quality of the goods on the market and is considered derelict in his duty if he does not use whatever knowledge he possesses in such judgment. If he fails to judge correctly, he often has practically no legal recourse.

Conditions in the medical field are almost the reverse. Medical services are not sold by a third party on a general market through salesmanship. The buyer is not able to judge the service. He must depend on the reputation of the physician, especially among his colleagues, and on control of the quality of medical care by professional associations. Almost all the features of sickness insurance, as it exists at present, seem designed to destroy these characteristics that have always been considered the essentials of good medical service.

Sickness insurance almost automatically seeks to follow industrial patterns and to make the physician an employee, chosen by some third party, to supply standardized and depersonalized services, to a medical market which the patient must patronize. Against these tendencies the physicians of every country are desperately fighting, because they maintain that it is just this personal relation between patient and practitioner that is the essential ingredient of good medical service.

It is well to remember, in considering this question of free choice, that many, perhaps a majority, of the old voluntary associations provided for free choice, that whenever the members have been able to express their opinions they have always favored free choice, and that, in Germany, one of the inducements used by Social Democratic politicians to capture the *Krankenkassen* was the promise of free choice.<sup>45</sup> The administrators of the societies, in their assumed function of employers and managers of a lay organization, have always fought the right of the insured to choose their own physician.

This question of the free choice of physician involves a number of other questions. The insurance societies insist that, if the patient is allowed a free choice, only

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45. Helbich, Karl: *Aerzte und Sozialversicherung in der Tschechoslowakischen Republic*, Die Arztfrage, *Aerzte und Krankenkassen*, p. 160; Lehman, Helmut, *op. cit.*, pp. 8-9.

those physicians will be chosen who are liberal with certificates of incapacity to work and with favored drugs and other services. There is much truth in this, which only proves that a condition has been created in which the insured are not primarily interested in being cured but far more in getting all they can in return for their contributions.

In the more recent systems—France, Great Britain and the Scandinavian countries—the physicians seem to be winning on this issue, and in Germany there has been considerable extension of the right of the patient to choose until now there is much freedom of choice in most districts. The present situation is shown in table 3.

The reports as given in this table, however, indicate a much wider extension of real free choice than actually exists, as in many countries there are not only exceptions in some societies and localities, but many countries have conditions of admission to insurance practice that really exclude a considerable number of physicians already licensed to practice. Indeed, the British and the French systems are almost the only ones in which every physician, unless specially disqualified by his own actions, is free to enter insurance practice and to be freely chosen by the insured.

The method and the amount of the payment to physicians is always a point of sharp controversy. In the British and French systems the societies have nothing to say about the form or amount of such payments. The medical associations of those countries, at the time the law was being formulated, succeeded in divorcing the societies from all direct relations with the medical profession in connection with medical care. The payments to physicians in England are made directly from the insurance funds by the Ministry of Health.

For several years prior to 1931 this payment amounted to 9 shillings per year for each person on the physician's "panel" who must be given all medical service within the field of a general practitioner. In 1931 this per capita sum was reduced 10 per cent and at par exchange amounts to about \$1.95 per year. No single physician is allowed to have more than 2,500 patients. The average annual income for several years of physicians from insurance practice has been about \$2,000.<sup>48</sup>

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<sup>48</sup> The history of changes in compensation is given in the British Medical Journal, Jan. 14, 1933, p. 1477.



The British system does not include dependents, for whose care the physician must be paid by the individual who employed him. Consequently the foregoing sum is in most cases considerably increased from this source and also from private practice among the noninsured.

In France also the medical associations were successful in preventing the entrance of any "third party" into any of the relations of physician and patient. The physician deals with the insured person exactly as with any private patient, except that he certifies as to the character of the service given. The patient takes this certificate to the society and receives payment according to a fixed scale, which is supposed to amount to from 75 to 80 per cent of the fee of the physician. The physician, however, is not bound to charge according to the legal schedule of reimbursement. His fee is purely a matter of private arrangement between him and his patient.

These two countries, however, are peculiar in this absence of financial dependence on insurance carriers. In nearly all other countries the payment of physicians is dependent on bargaining with the societies.

In Sweden, while contracts are made between the medical association and the insurance carriers and a fee schedule exists, the physician, as in France, is not bound by the fee schedule but may, if he wishes, charge a higher fee to the patient. Under all conditions the society pays only from 75 to 80 per cent of the fee schedule rate and the patient pays the remainder.<sup>47</sup>

The costs of medical care under all systems of insurance are steadily increasing. In part, this is due to constant rapid improvements in medical diagnosis and treatment. To a much larger degree under insurance, it is due to the incessant demand for more service once that service has already been paid for. This is illustrated by the fact that the number of cases of "sickness" among dependents increases even faster than among insured adults, in spite of the effect of cash benefits among the latter which does not apply to dependents.<sup>48</sup>

The insurance societies are constantly urging an extension of medical services and at the same time fighting any adequate payment of physicians. They

47. Rystedt, Gottfried: *Revue Internationale*, November 1931, pp. 69-72.

48. Finkenrath, Kurt: *Aus der Krankenversicherung in Oesterreich*. *Deutsche medizinische Wochenschrift*, Aug. 8, 1930, p. 1356.

will expend vast sums for showy headquarters and for largely superfluous medical and convalescent institutions, while insisting that the physician on whom the whole character of the service depends must work under conditions and for a reward that renders good service impossible. One may search all the multitudinous legislative proposals for increased benefits without finding any suggestion of better personal care or for any extension of such care through health examination, immunization or other personal service furnished by physicians. An examination of the mass of literature issued by the insurance carriers boasting of the services furnished to the insured will also find small mention and less praise of the work of the individual physician. Consciously or unconsciously this whole program of the societies is directed toward keeping the physician dependent and subject to the will of the society.

If this attitude is kept in mind it will explain why there is so hot a fight in so many countries over forms of payment. Three forms of payment are in operation in the different systems of insurance—often all of them in the same system: salaries, per capita lump sums and according to the medical act. The societies favor and the physicians oppose these in the order given.<sup>49</sup>

Under the salaried plan the physician is simply an employee, subject to the orders of his employer, the society. It is the ideal relation according to those who wish to organize medicine on industrial patterns. It is the method used in clinics, laboratories, hospitals, sanatoriums, convalescent homes and similar institutions owned and operated by the societies, and used by them as a means of outcompeting and breaking the resistance of independent practitioners. This system is dominant in Bulgaria, Poland, Rumania and a few other countries and is being pushed in Czechoslovakia, Jugoslavia, Austria and wherever the law permits the societies to create such institutions as a means of furnishing medical service to the insured. It is practically prohibited in the insurance systems of England and France.

The medical professions of all countries are unanimous in declaring that the system of supplying service through such institutions with salaried physicians is

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49. The exception is in the British system, in which, owing to the peculiar situation described above, the physicians have expressed approval of the per capita plan.

destructive of the best features of service and degrading to the profession.

The lump sum payment is frankly urged as a method of restricting the services given by physicians. It is maintained that if a physician is paid by a periodic per capita sum that he will not make unnecessary calls or perform unnecessary services. It does not seem to occur to those who use this reasoning that a physician who would make unnecessary calls and pad his record of service would probably not hesitate to fail to give necessary attention. In this case, it would be the sick persons and not the society's treasury that would suffer.

However, this scheme has not worked out as the societies expected. The physicians, whether they neglected the sick or not, found a way to shift their burden of work. It is now recognized that the introduction of the lump sum system was followed in a few years by a great increase in hospitalization and institutional care. Chronic and difficult cases, requiring much work, are certified to institutions, thus relieving the physician. The result has been an overloading of the hospitals in every country using this system. The English hospitals, in spite of the provisions discussed, are so overcrowded as to be almost bankrupt and to compel extensive reorganization.

An English medical journal has the following description and comment on this situation:<sup>50</sup>

In the very remarkable report issued by the Government Actuary on the examination of sickness and disablement experience of a group of approved societies concerned with the administration of National Health Insurance for the years 1921-1927, it is recorded that the claims for sickness benefit by men rose by 41 per cent and disablement benefit by 85 per cent, and the increase is still more formidable in the case of women, in some sections of the report increases of over 100 per cent being mentioned. A similar conclusion pointing to a certain degree of failure of that scheme seems to be inevitable from a consideration of the number of patients attending the Voluntary Hospitals, the increase in the last decade being most pronounced and the number progressively rises every year. One would have thought that the establishment of National Health Insurance, with its compulsory contributory clauses bringing very large numbers of the working population under

50. Journal of State Medicine, February 1933, p. 80. See also the Lancet, Jan. 2, 1932, p. 29. Naskomeion, Supplement, Proceedings International Hospital Conference, 1931, on Influence of Social Insurance on Hospital Practice. Also Canadian Medical Association Journal, February 1932, p. 185.

its operation, would have depleted the outpatient departments at the Voluntary Hospitals, and this expected result actually occurred in the years immediately succeeding the passage of the Act; from 1911-20 the numbers of outpatients materially diminished. From 1920 onwards, however, the increase has been so great that the attendances now exceed the figure for the last years prior to the passage of the Act.

The English correspondent of *The Journal of the American Medical Association* reports, in reply to a question concerning the effect of insurance on hospitals:

There is a tendency to send a panel patient to the hospital for the smallest operation or anything requiring special treatment of any kind.

Wherever in Germany the lump sum system is used there is the same complaint that the physicians send all cases requiring continuous care to the hospital.<sup>51</sup> The worst phrase of this situation is the condition created by overcrowding in the hospitals, which is described as follows: <sup>52</sup>

In the majority of hospitals (I know of no exceptions) the third class in which the service is paid for by the *krankenkasse*, is so frightful that I personally, when I stepped into these wards as a student, always felt my heart wrung. I positively will not reproach any one for present conditions. That nothing better is possible, no one knows better than I. Therefore I am determined to change the conditions, because I know that under present conditions there is no escape for the miserable insured.

There lay, in one great hall, closely packed together, twenty to thirty human beings, very sick, slightly sick and convalescent. The convalescent must remain still as mice throughout the whole day in order not to disturb the seriously sick. The latter were naturally greatly disturbed by the noise, which was nevertheless unavoidable. A number of those in the hall coughed all night, others groaned with pain.

An attempt to meet the problem caused by the overcrowding and consequent impoverishment of English hospitals through a system of voluntary hospital insurance, known as "Contributory Schemes," while relieving the hospitals to some degree, has created other problems. It has so further stimulated the tendency to have recourse to the hospitals for every complaint as to threaten the complete destruction of private practice in large sections of the community. At the 1933

51. Baeumer, Waldemar: *Die Krankenversicherung*, pp. 37-39 and 50-51. Weddigen, Walter: *Grundfragen der Sozialversicherungsreform*, p. 95.

52. Baeumer: *Die Krankenversicherung*, pp. 115-116.

meeting of the British Medical Association, according to press reports,<sup>53</sup> "one doctor declared that 'the Hospital Savings Association is stealing most of the private practices of the doctors in London. Unless there is some scheme by which this flow to the outpatients' departments of the hospitals can be checked, ruin is in store for most of the practitioners in the poorer areas of London.'"

When the system of payment by the medical act is introduced, there is ample proof that the charges of excessive practice, brought by the societies, are largely justified. Medical writers who defend this system admit its susceptibility to abuse unless strictly controlled by professional associations. This the societies will not permit. The physician who refused to yield to the demands of patients would soon lose his practice, and he cannot convince them that his refusal is due to medical judgments and not to fear of discipline by the society.

The effect of the two systems may be summed up by saying that when payment is by a per capita lump sum or salary there is no financial incentive to the physician to give continuous careful care; while, when payment is by the medical act, the demands of the patient and the financial interests of the physician are joined to encourage excessive practice.

It is practically impossible from any available data to give any certain answer to the question of whether insurance has any inherent tendency to increase or decrease the annual income of the average physician. There is no standard by which to determine in any country whether, and to what extent, incomes would have risen or fallen without insurance. The opinions of three correspondents of *The Journal of the American Medical Association* as to the effects of three quite widely diverse systems probably are as accurate as any such general opinions could be.

From Austria comes a very full discussion, which covers so many points that it seems worthy of quotation, almost in full:

The health insurance system existing in this country is compulsory and is based on the law of 1892 and has been supplemented after the war. The original law of 1892 dealt only with persons receiving a daily, weekly or monthly payment for their

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53. The Sunday Times, London, July 23, 1933.

work and comprised only laborers, artisans, factory hands and the like, as long as they were employed by private persons, firms or corporations. It ensured medical help and hospital accommodation besides a sick-pay from the first day of illness for its members. Gradually the scope of the sickness insurance bodies extended to wider circles of the population, so that within the next twenty years nearly the entire bulk of wage earners came under the influence of the system, except persons serving under the government or the municipalities or the state railways.

As the number of insured persons increased, the income of the individual physician was affected by the system in so far as in the first years an increasing number of medical men were appointed at a fixed, although comparatively low, salary, meaning a real increase of their income. The greater part of these insured persons would never have thought of going to a private doctor. They were looked after in hospitals and ambulatories.

With the extension of compulsory sickness insurance to better paid classes of the population, a certain loss of private income was noted, but even then the public was not very much in favor of calling on a "krankenkassa-doktor" and preferred to pay a reduced fee to the medical man of its confidence. For it must not be forgotten that the appointed doctor had to be consulted by the members living in his work district; the patients could not choose their doctor. *The primary effect of sickness insurance was thus an increase of income for certain doctors.* Only in the last twenty years the conditions have undergone a complete change.

In the years 1908 and 1912 the Sickness Insurance Act was extended to all persons earning a living by salaries in commercial or industrial enterprises or in the trades. Theoretically even the managing director and the well paid highest clerks, who were forced to belong to their respective krankenkassa, were entitled to free medical help by the doctors appointed for the district. But as a rule these classes of patients formerly preferred to consult their own private physician. At this period numerous complaints started about the dwindling of medical income. Not a few members of the krankenkassa, who hitherto had consulted private doctors, preferred to consult them in their new position as insurance doctors, if they happened to obtain such appointments. At that time the medical profession began to aim at limiting the eligibility for membership in sickness insurance societies to a certain amount of income or salary on the part of the insured member. . . .

In the last few years a quite new system of sickness insurance is quickly gaining ground. It is based on pure business lines, is a private enterprise, and refunds to its members a certain sum for medical treatments and other expenses pertaining to illness. It has nothing to do with the patient's medical attendant. Anybody may become a member of this insurance body. A similar institution has been founded for independent business owners. With the exception of the last named system of sick-

ness insurance all the other systems have had the *effect of cutting down, especially in the last few years, the income of the individual physician by at least 35 to 50 per cent of his former income.* At present about 40 per cent of the total population of Austria are insured against sickness, so that there is hardly any doctor who does not work somehow under the sickness insurance system.

The opinion of the English correspondent is that "it has increased incomes, because they are paid without fail for a class of patients that often could not pay before."

The Czechoslovakian correspondent says in reply to the question "How does health insurance affect the individual physician as to income?"

The question is difficult to be answered in a general way as it is put in the questionnaire. When the insurance is newly introduced into a country it usually means that the physician receives from his old patients less than he did before, but on the other hand he finds new patients that did not come to him before when they had to pay a full fee. The sum of the income of the physician working under insurance is not necessarily lower than before the introduction of the insurance. If the physician lowers the standard of his work and increases its amount, the introduction of insurance may actually mean an increase of his income. If a fully occupied medical practitioner comes under the system of insurance and if he continues the same method of thorough work as before the introduction of insurance, this change undoubtedly means a curtailment of his income.

The societies always seek to control the admission of physicians to insurance practice. In many countries this is the largest, and in some almost the only, field of practice. The societies are, under these conditions, acting as a licensing body. Without any of the necessary qualifications they have usurped the positions of the state, educational institutions and professional associations in determining which of those physicians whom the proper authorities have already declared qualified shall really be permitted to practice their profession. To just the extent that control of admission is exercised by the societies, the power of licensure is usurped.

When stated in this bold but accurate manner, few would defend the right of any lay body to control admission to insurance practice. When, however, the position of the societies is stated as involving nothing more than the right, universally recognized in industry,

of the employer freely to pick his employees, this attitude finds plenty of defenders not only among representatives of European insurance carriers but also among a host of American employers and insurance companies and most of the advocates of insurance methods of medical care.

The issue of admission to insurance practice did not arise at the beginning of sickness insurance any more than it did in the beginning of workmen's compensation legislation in the United States. It was only when insurance systems had grown to a position where they monopolized so large a part of the field of medical practice that exclusion from it practically disqualified a physician from practice that this question became of paramount importance. It was this condition that made it possible for the German Nazis to destroy their political opponents in the ranks of physicians by simply excluding them from insurance practice.

The carriers pretend to set up special standards for admission to insurance practice. They demand a sort of preliminary "internship" or practice period, often of several years, as an "assistant" to an insurance physician. They create special graduate institutions to train prospective physicians in "social medicine" as a condition of admittance to insurance practice. They set up the claim that such practice is a new specialty in medicine. When this special training is examined, it is found to consist primarily in admonitions about "economical practice" and methods of detecting malingering. Stripped of all camouflage and rationalization, it is primarily for the purpose of taming the physician, making him willing to accept the control of the societies and more interested in protecting the society treasury than the health of his patients.<sup>54</sup>

Insurance seems to have a tendency to influence graduate study by physicians in two undesirable directions. There appears to be less interest in scientific progress and an increasing tendency to study those administrative phases of medicine which prepare for the favor of the insurance societies. These attitudes are described by a German physician as follows: <sup>55</sup>

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54. *Jahrbuch der Krankenversicherung*, p. 94. *Compte Rendu*, 1930, pp. 73-75.

55. Finkenrath, Kurt: *Krankenhilfe und Gesundheitsfürsorge durch die Ärzteschaft*, pp. 119-121.



I made a statistical study in 1919 to determine from what sections of Berlin the majority of the physicians came to attend the graduate courses of the Central Committee of the Kaiserin Friederich-Haus. This made clear the fact that three fourths of all participants came from the West and Southwest and that all other sections of Greater Berlin only furnished one quarter. From this division the conclusion was drawn that the physicians who had an interest in further education were overwhelmingly those who still had some share of private practice, while the great mass of the insurance physicians were far from desiring any further education.

It is certainly true that the demand for insurance physicians today is no longer dependent on the knowledge of the selected physicians but that other points of view have important influence in their selection. These "other points of view" can so dominate that their effect wholly outweighs the knowledge of the physician, and many with a very large practice owe this perhaps much more to these "other points of view" than to their knowledge. The result is that from this side little value is placed on further education. . . .

The Seminar for Social Medicine, as the name indicates, emphasizes social medicine. In previous years it covered all phases of social medicine, but recently it has been almost exclusively occupied with preparation for insurance practice. . . . The courses are naturally greatly patronized, because attendance is made a condition of admittance to insurance practice. . . . The program covers the following: Introduction to Imperial Insurance Regulations, Insurance Contracts with Physicians, and the Berlin Association of Insurance Physicians, The Organization and Operation of the Fee Schedule of the H $\ddot{a}$ rtmannbund, The Activities of the Krankenkasse and Its Organization, Insurance Physician Regulations, The Insurance Physician and Chronic Diseases, The Ethical and Social Duties of the Insurance Physician.

The official attitude of the insurance societies on this subject was summed up by a speaker at their international congress:<sup>56</sup>

It is necessary to begin with the medical students. We think the unions of insurance societies should organize in the university centers, for the benefit of the students, special courses on insurance and social medicine, and that these courses ought to be obligatory for the students who desire later to practice for the insurance societies. The faculties of medicine should themselves, in their curricula and regulations, give greater attention than at present to the necessities of sickness insurance and should establish compulsory examinations in social medicine.

56. Franz Korris, Secretary, German Insurance Societies of Czechoslovakia, *Compte Rendu*, 1930, p. 75.

In particular, the individualist spirit, which has developed among the physicians the mentality of the little artisan in place of making them conscious of their social mission, in place of preparing for their future profession, which must necessarily be within the organization of sickness insurance—this spirit ought finally to disappear in the medical faculties.

On this point, as on many others, there is a sharp distinction between the earlier systems of central European countries, created according to the German model, and the later systems of France, Great Britain and the Scandinavian countries, which had an opportunity to profit by the errors of the older schemes. In these more recent systems the medical associations have been successful in securing the incorporation of provisions permitting all members of the national professional associations or, in some cases, all licensed physicians freely to enter insurance practice. It is significant that no one claims that such unlimited admission has brought any of the evils that the defenders of society controlled admission have claimed would follow. On the contrary, many of the evils which exist under the systems in which societies control admissions, and which that control is largely designed to prevent, have never appeared where admission and choice of physician by the patient are most free.

All these regulations and restrictions are but preliminary measures to strengthen lay control over insurance medical practice, and it is around this control that the fight is hottest. The conflict centers around the effort to make the physicians the police of the society's funds. One might think that the societies would rather insist on assuming complete control and responsibility for all financial measures and would be eager to exclude the physicians from all such control and responsibility.

On the contrary, the societies fight all measures to compel them to assume this responsibility. In the English system an effort was made, largely through the action of the British Medical Association, completely to separate the financial and medical sides of the system. To the nonlegal mind the provisions of the existing English law and regulations place all responsibility for the payment of cash relief on the insurance carriers. This did not suit the purpose of the carriers to use the physicians as a scapegoat against which criticisms of

the abuses of insurance can be directed.<sup>57</sup> Even in the English system it is the physicians, and not the societies, or the inherent character of insurance, that is blamed for excessive cash payment, with a consequent increase of "sickness" rates, as well as for excessive practice, the preponderance of minor diseases demanding unnecessary attention and for overmedication.

The societies are constantly complaining that the "physicians hold the key to the societies' treasury" or that they can "draw blank checks on the societies' funds," but they fight every effort to remove this power from the physicians and vest it in the society administration. They continue to insist that the physicians perform these police functions, although the physicians themselves continuously protest that to do so destroys their ability properly to perform their medical functions.

We are here very close to the heart of the most puzzling question in the whole problem of sickness insurance: whether it is possible to provide medical service out of a large impersonal fund, created by a multitude of contributions, without compelling the physician to accept the dual and mutually destructive functions of detective and medical attendant. German commentators frequently refer to this as the "Sphinx riddle of insurance," which must be solved if the system is to continue, but for which no satisfactory solution has yet been found.<sup>58</sup>

A consequence of this division of responsibilities is the creation in every insurance scheme of a secondary system to control the practicing physicians. The active agents in this control must be physicians, because no one else even claims to be competent to do it, although lay administrators of the carriers presume to prescribe the detailed specifications of such control.<sup>59</sup> The societies insist that these control physicians shall be

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57. Baeumer, *Die Krankenversicherung*, p. 13, says of a similar situation in Germany: "But the scapegoat had already been firmly fixed in the law, namely, the medical profession, since without medical endorsement no cash relief would be paid. Eureka! The law is saved, everything is all right, these rascally physicians are to blame for all the defects, since either because of laziness or because they fear to lose their practice they will not hunt out the malingerers and send them back to work. This was the theme, stated in a more or less definite way, of all the organs under krankenkassen influence."

58. Dr. Scholl: Address at Bavarian Medical Association Convention, *Bayerische Arztezeitung*, Oct. 18, 1930, p. 439.

59. Helmut Lehman, at fourth Conference of International Union of Insurance Societies, *Compte Rendu*, 1930, p. 164. Jauniaux, A.: *Cent Années de Mutualité en Belgique*, pp. 100 et seq.

employed by and be responsible to the societies alone. Objection is made to their membership in any organization of insurance physicians. They are to be the agents of the societies to act as a sort of foreman or supervising police of the body of practitioners.

Such supervision, where the decisions of the practicing physician are constantly being revised and reversed by supervising physicians, who are there primarily to protect the financial interest of the insurance carriers, further aggravates all the conflicts that have been described. The latter constantly certify as capable for work a large percentage (usually about one half) of those previously certified as incapable by the attending physician. Without in any way modifying what has already been said about the tendency of the insured to exploit the cash benefit and secure unnecessary medical attention, it must be said that little weight can be given to the frequently quoted figures of the percentages disapproved by supervising physicians, unless such figures are subjected to careful analysis. Just as the original figures of certification are influenced more by financial than by pathologic considerations, so these statistics of secondary examinations more often reflect professional antagonisms, administrative pressure and other similar attitudes rather than scientific professional judgments.

A previously quoted writer points out that, in some cases when still a third examination was demanded and granted before a commission, about one half of those certified by the supervising physician as capable of returning to employment were again declared incapable of work. He comments further on this situation:<sup>60</sup>

Some of those who have been certified as sick and are referred for a second investigation certainly come with a bad conscience. But this does not say that in all cases the certification was unjustifiable, for even those who were properly declared incapable of work, but by the time of the reexamination have again recovered, do not go for the reexamination but rather to their own physician, who certifies them as again capable of work. Finally, many of the insured have so great a dislike of the *vertrauensarzt* that they would rather go back to work even if sick.

The effect on thousands of patients, who are thus shuttled back and forth by conflicting opinions of phy-

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60. Finkenrath: *Krankenhilfe und Gesundheitsfürsorge*, pp. 58-59.

sicians, in destroying all confidence in professional integrity and competence scarcely needs discussion.

Again, it is significant that in France, Great Britain and Denmark,<sup>61</sup> where the societies have been defeated in their efforts to maintain a secondary control, the system works far more smoothly than in Germany, Austria and other countries where the societies have had their way. Lay control has never been successful in checking excessive sickness claims and has always produced a multitude of undesirable and usually unexpected results.

In Great Britain, where the general medical officers, who are charged with this work of supervision, are the employees of the Ministry of Health and therefore independent of the societies, there is so little friction between them and the practicing physicians that a proposal to abolish the general medical officers met with a protest from the insurance practitioners, who make considerable use of such officers as free consultants. They are, of course, members of the same professional association as the insurance physicians and are subject to the same influences.<sup>62</sup>

In France also the supervising force is independent of the societies and controlled by the professional association. It may be set down as an invariable rule, so far as experience up to the present time is a guide, that the quality of the service, and the general satisfaction, not only of the physicians but also of the patients and ultimately even the societies, increases in almost direct ratio with the extent to which all phases of medical practice are controlled by professional associations without lay interference.

The work of the physician under insurance differs in many ways from that in private practice. This is inevitable, since medical service is closely dependent on personal relations and these relations are deeply affected by the presence of insurance.

The patient, especially in the older systems where mental attitudes and patterns have had time to become

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61. "There is no sort of technical control. In Copenhagen, alone, the societies employ supervisors whose only duty is to make certain visits to the residence of the insured to see that he stays in bed or in the house and that he follows the instructions of the physicians; or that the hours in which he goes out are those which are permitted to a sick person in his condition . . ." Report of Danish Medical Association, *Revue Internationale*, August 1931, p. 115.

62. The ways by which the efficiency of the medical service is maintained in the English system are discussed by McCleary, G. F.: *National Health Insurance*, pp. 143-148.

definite, comes to the physician with a quite different mental background from that possessed by the private patient, and this background has a significant influence on the problems of diagnosis and treatment. The insurance patient comes with the feeling that the system to which he has been contributing owes him something and, as countless observations under a great diversity of such systems proves, patients in insurance systems also have a feeling that one of the duties of the physician is to prevent the patient from getting what he feels the system owes him. He knows that the services given him by the physician will bring no special reward to the latter but, on the contrary, that the less that is done the more the physician will have succeeded in protecting the general funds to which the patient was but one contributor.

Even if there is no question of a cash payment, the history of medical benefits under all systems of insurance has shown that a very large percentage of patients come for ailments not really requiring medical attention. At a free or low-pay clinic these can be turned away and if they visit an individual practitioner they will at least be discouraged from continuous useless visits by the need of corresponding payments. But the insured has already paid and has a right—which he never forgets—to demand service.

The physician knows all these things also; they have been impressed on him daily and hourly for years. He approaches the patient with the expectation that he will exaggerate his symptoms and make demands for excessive treatment. The physician knows that if he yields to these demands he endangers his position with the insurance administration; if he does not yield, he angers his patient and may turn him away without proper diagnosis.

If the insured claims to be incapable of work, and often in other cases, the diagnosis must be reported at once to the administrators of the insurance scheme. Along with this must go a prognosis of the probable duration of the disabling sickness, all of which, in many cases, is beyond the powers of real medical science.

When it comes to treatment, the difficulties arising out of the situations created by insurance multiply. As has been repeatedly pointed out, cash benefits destroy the "will to get well," a principal therapeutic agent in

many sicknesses. The physician is not a free agent in planning his treatment. From the side of the patient, who is determined to secure his rights, come demands that he be given all the fancy and expensive treatment that some friend or acquaintance has been able to get.<sup>63</sup> If these are refused, a physician loses patients and income; if they are given, he loses his self respect, his scientific honor and the favor of the insurance administrators.

No system has been able entirely to avoid restriction on prescribing. Table 3 lists the forms which these restrictions have taken in the principal systems. These bare statements, however, fail to give any adequate picture of the situation. It is probable there would be general medical agreement that most of the things which are prohibited in prescriptions, and most of the regulations requiring the use of remedies found in a standard or even limited pharmacopeia, are in accord with sound practice.

Dr. Schaeftgen, secretary of the Luxemburg Medical Association, as the result of the analysis of the replies to a questionnaire, sent to the medical associations of all insurance countries by the International Association of Physicians, came to the conclusion that "there is not complete freedom of prescription in any country."<sup>64</sup>

Restrictions in no system are confined to these formal regulations, which are themselves, in spite of much that has been said in their support, more or less galling and humiliating to a physician. They set limits to his scientific judgment, something no true scientist can quietly endure. They are fixed by lay organizations, not primarily for the benefit of the patient but for the protection of a society treasury.

The really aggravating and harmful feature of restrictions on prescribing is found in the continuous pressure, backed up by a sort of espionage, to compel the physician to keep within a certain standard or average. Any one who exceeds this average is subject to criticism and a sort of irritating hectoring from various sources.

In the English system, where such restrictions are far less offensive than in many continental schemes, the cost of the drugs prescribed by each physician is tabu-

63. Baeumer: *Die Krankenversicherung*, pp. 34-36.

64. *Revue Internationale*, November 1928, pp. 85-90.

lated (at a tremendous expense) and if he exceeds a determined average he is apt to be warned and, if this warning is not effective, sterner measures may be used.

At the same time the patients, who are well aware of these restrictions and usually are firmly convinced that their only object is to cheapen the service in contrast with what is given to those who pay for their care individually, clamor for just these forbidden articles. The insured are just as susceptible as the noninsured to the suggestions of advertisers. Furthermore, the insured are certain that insurance deprives them of the marvelous qualities of these advertised remedies. The discussions of every system in which drugs and medical appliances are furnished as a part of the insurance benefit are filled with stories of how the patients clamor for expensive advertised drugs and lose confidence in the physician who refuses to prescribe them.

In a few systems, as noted in table 2, the patient pays the whole or part of the cost of drugs and medical supplies. While this at once does away with most of the evils of over medication, the societies always fight any such provisions. They wish a continuous extension of benefits which they can use as "selling points" in getting new members, for, in spite of the compulsory character of most systems, competition between societies in securing members and in business efficiency is encouraged by governments, although the lack of such efficiency is now leading to demands for consolidation of societies.

Once more it comes back to what, for lack of a better term, may be called the mental atmosphere, which is created in all phases of medical practice and under insurance by the continuous conflict of financial and medical motives.

However great may be the difference as to these policies, there is practically unanimous testimony that the effect of every system of insurance providing for free drugs is greatly to increase the demand for such drugs. The insured demand their "share" of the drugs that are being "given away," much as visitors to an exhibition collect "free samples." German physicians tell how patients insist on roentgenograms, whether needed or not, so that they can boast of at least "getting all that was coming to them." They always demand prescriptions, although there are stories of how the



bottles and packages are sometimes thrown away and often not used.<sup>65</sup>

This influence of excessive medication under the English system is reported to have extended beyond the scope of the insured. A recent report describes the situation here:<sup>66</sup>

At the Sanitary Congress, Dr. G. H. Pearce, health officer of Batley, Yorkshire, delivered his presidential address, in which he criticized the national insurance system. He said: "A large proportion of the medicine dispensed today under this system is both useless and unnecessary and an entire waste of money. Unfortunately, the patient does not believe this and insists on having his bottle. The general practitioner who tells the majority of his patients that they do not need medicine will soon require much smaller consulting rooms." It will be noticed that this condemnation extends beyond the insurance system to medical practice in general. The English working class has, in the words of the late Sir Frederick Treves, "a craving for bottles of medicine which is second to the craving for strong drink." However, in the case of insurance practice the evil is intensified, for the craving can be indulged in without any additional payment, while in private practice it costs something.

Patients dissatisfied with insurance service, which they receive without cost, flock to quacks, who must be paid for their services. A circular issued by the German Association to fight quackery says:<sup>67</sup>

Do you know that there are in Germany, according to official statistics, 12,942 quacks? These do not include all the traveling representatives of patent medicine firms (Heilmittelfirmen), the numerous astrologists, chiromancers, and similar miracle workers. . . .

Do you know that the quacks have a hundred and fifty journals of their own concealed under intellectual, religious, cultural or mystical-occult cloaks through which they conduct an irresponsible advertising of their nostrums? . . .

Do you know that in Germany there are more than twenty large nation-wide organizations of quacks with hundreds of subordinate unions and thousands of local groups?

A speaker<sup>68</sup> at a meeting of the Düsseldorf Medical Society declares that the total number of quacks in Germany exceeds 50,000. Austrian physicians complain of a similar plague. It cannot be charged that

65. Winands: *Zentralblatt für Reichsversicherung und Reichsversorgung*, June 1930, p. 200 et seq.

66. London letter, *Journal A. M. A.*, July 22, 1933, p. 293.

67. *Aerztliche Mitteilungen*, March 18, 1933, p. 254.

68. *Münchener medizinische Wochenschrift*. July 21, 1933, p. 1153.

insurance creates quackery, for some countries with insurance systems have comparatively few quacks, while in some noninsurance countries they exist in fairly large numbers. But the evidence cited proves that free medical service does not prevent a large scale practice of quackery.

Reference has already been made to the great expansion and peculiar position within the systems of such auxiliary services as hospitals, clinics, baths, laboratories and sanatoriums. Where these are operated by public authorities they become a form of additional and expensive subsidy to the insurance scheme. Insurance patients, especially in hospitals, are, in practically every country, cared for on a semi-indigent basis at far less than the actual cost of hospitalization. While the amount of the indirect subsidy so given must run into tremendous sums, it is never included in the cost of the operation of such systems.<sup>69</sup>

The British societies, if able to accumulate a surplus, after supplying the services required by law, are permitted to offer "additional benefits" as a means of attracting contributors. These take a number of forms—dental service (the most popular), hospitalization, extra cash, convalescent care, and so on. This has, in one respect at least, the same effect as is produced in schemes in which the societies are permitted to own and operate medical institutions. These "additional benefits" become "selling points," whose value is overstressed.

The printed reports and other publications of the societies in all countries always emphasize the value of the services furnished directly by the institutions. The number of roentgenograms and physical therapy treatments in society laboratories, the number of insured sent to society owned hospitals, baths and cures, is always a matter for boasting, while the number of visits by physicians is a matter of loud complaint.

The physicians also complain of the tendency continuously to raise the income limit of those admitted to insurance. In Austria all limits have been removed for government employees, although many of these have large incomes in addition to their salaries. This has

69. A similar shifting of costs in workmen's compensation is described in *Medical Relations Under Workmen's Compensation, 1933*, pp. 86-89.

practically annihilated the few previously remaining remnants of private practice.<sup>70</sup>

There are a number of reasons that lead the societies to press for every additional extension. Every increase of scope not only adds to their political and financial power but, by narrowing the field of private practice, renders the physician more helpless to fight lay domination.

The conflict between physicians and societies has led to an international organization of both sides. The International Association of Physicians (Association professionnelle internationale des médecins) has its headquarters in Paris and its governing body is composed of the secretaries of various national medical associations and includes practically all countries having systems of health insurance and some other countries not having insurance systems. The association devotes its attention to the economic and social side of medicine, and particularly to the relations of the medical profession to sickness insurance. It has conducted a number of exhaustive inquiries into all phases of such insurance, and after four years of discussion, in September 1931, unanimously adopted a series of statements embodying the attitude of the various associations represented toward sickness insurance. In considering these it must be remembered that, in practically all the countries represented, these associations were faced with an accomplished fact in the shape of existing systems of insurance and did not discuss the question of the introduction of such systems where they do not now exist. This statement, which follows, may be assumed to represent the attitude of physicians to sickness institutions in countries where such institutions exist (*italics in original*):

#### PREAMBLE

I. The International Professional Association of Physicians fully approves, for the economically weak class of society, the principle of social insurance, which constitutes a great social advance, as well as a powerful factor in the prosperity and well being of the nations.

II. The principles herewith set forth represent only those provisions which, by the very fact of its fundamental rôle in

70. Stritzko, Joseph: Die Aerzte Oesterreichs und die Sozialversicherung, *Die Arztfrage*, 1926, pp. 102-121. *Revue Internationale*, November 1929, pp. 52-54, and February 1933, pp. 57-61.

the operation of sickness insurance, the medical corps has a right to insist on.

III. In formulating these principles, as the result of long and comprehensive investigations, and as conclusions based on these investigations, the International Professional Association of Physicians has been guided, not alone by solicitude for the special interests of the medical corps, but above all by its duty toward all the sick, and by the necessities for the proper functioning of the insurance societies.

But it maintains that *only the closest cooperation* between the insurance societies and all other institutions of social insurance with the representatives of the organized medical corps guarantees the proper functioning of sickness insurance and its development.

IV. It is necessary that the practicing physicians be heard, through their professional associations, in the preparation of laws and regulations concerning sickness insurance and also in all modifications in the course of their application. The physicians are the natural pillars of sickness insurance; they have a full *right to be heard* on this subject. The International Professional Association of Physicians insists on this point with all its energy, backed by the indisputable defects—becoming more and more evident—committed by the majority of existing legislation, as a result of the absence of the practicing physicians.

V. The International Professional Association of Physicians also emphatically demands the autonomy of the medical service, including the material and moral *independence* of the physician, and this in the interest of the patients themselves.

It is proper, to be sure, that the medical corps remain always outside all conflicts of a political or religious character that may arise within the directing committee of the societies and that the position of the medical corps and the physicians shall not be affected by any changes whatever in the composition of the directing committees. Moreover, experience has shown that in those countries where the physician is given a dignified, honorable and influential position in relation to the sickness societies, and where the medical profession preserves the liberal and independent character of the practice of medicine, there is the most fruitful development of sickness insurance.

VI. The International Professional Association of Physicians is of the opinion that sickness insurance, whether compulsory or voluntary, ought, from the social point of view, to be applied only to those persons who are incapable of meeting the necessary costs of medical care in case of sickness from their own resources. The field of insurance ought, therefore, to be limited by a maximum income, which is determined by the conditions of living in each country, with due consideration of all interests, including those of the medical corps.

VII. The socially insured in every country should be entitled to receive medical care up to the age limit which entitles them to old-age insurance or to care by analogous institutes.

It is also clear that the idea of social insurance cannot be realized if the *members of the family* of the insured (direct members: wife and minor children) do not share the benefits of sickness insurance.

VIII. In order not to remove the moral responsibility of the insured in his daily life, in order to secure a normal and healthy practice of medicine, and even in the interest of the sick, insurance legislation should always require the *insured to share* in the cost of medical care and drugs, which share may be very modest, but a share fixed by the law. The application of this principle should be adjusted to the special conditions and needs of each country, but it should not result in a situation where those who have the greatest need of the relief furnished by the societies are deprived of help. (Subsidiary aid to the indigents should be furnished by some organization.)

For the same reason the cash payments during sickness should be so calculated as to exclude the temptation of the insured to abuse the benefits of insurance. But it is to be understood that the application of these principles should be varied to meet the special conditions and needs of each country.

#### ORGANIZATION OF MEDICAL SERVICE UNDER SICKNESS INSURANCE

IX. The International Professional Association of Physicians declares that its first duty is to proclaim that one of the principal factors in healing is mutual confidence between the patient and his physician. This implies the free choice of physician by the patient. (Freedom of confidence.) The International Professional Association of Physicians therefore demands, as a condition sine qua non of good functioning of medical service in sickness insurance that free choice be written into the text of legislation in all countries.

This free choice implies that "all" physicians authorized to practice in the country shall be qualified to care for the insured, subject to the reservation that they adhere to the agreements concluded in each country between the societies and the organized medical corps, of which every physician ought to be a member.

The principle of free choice shall be considered as maintained even if, in the rural sections, in consideration of special situations, choice is restricted to the nearest physician.

X. At all times, in general, in order to determine the relations between the societies and the medical corps, it is necessary to conclude *collective contracts* between the regional or local societies and the corresponding professional medical groups.

In those countries where the law requires that contracts be made between the societies and the organized medical corps, it is desirable that the respective delegates deal directly among themselves, without the intervention of any so-called impartial body, the members of which are too often incompetent to deal with the matter and are apt to rest their decisions on insufficiently justifiable bases, thereby not only endangering the interests of one of the contracting parties but also damaging the later good functioning of sickness insurance.

If such organizations as committees of arbitration do, nevertheless, exist in certain countries, the physicians should have equal representation on these, appointed exclusively by the organized medical corps.

XI. Every physician accepting the terms of the contract shall have the right to care for the patients of the society, without the latter having the power to designate certain special physicians, which would be contrary to freedom of confidence and free choice of physician by the patient, which should be limited only for very special and grave reasons, such as the proved unworthiness of the physician.

It is necessary to guard with jealous care to see that *professional secrecy* is observed in sickness insurance. In the interest of the good functioning of the societies it is useful for the physician to state the causes of the days of sickness. But the medical corps of each country should determine the regulations on this point with the government or with the organizations according to national customs.

XII. The care of medical specialists, as well as hospitalization of the sick in case of need and according to the course of the sickness, should be guaranteed to the insured.

The latter should also, if the budget permits, be given the benefit of further medical treatments and all therapeutic agencies.

XIII. In the interest of the sick, and in order to assure them of the most efficient care, the physicians cannot accept any restrictions on their *right to prescribe* and must have the power to order all useful and *irreplaceable* medicaments. The medical organizations should always, on the other hand, seek to suppress all expensive and superfluous medication, or what might be called "luxury treatment."

As to the duration of the care given to the insured the International Professional Association of Physicians is of the opinion that the medical services of insurance should be extended to cover the *total* duration of illness, or of an accident and its results, up to recovery or decease, or until the moment when the insured is admitted to a home or other social institution (old age or invalidity insurance).

XIV. It is contrary to a proper practice of medicine that the payment of physicians should be by a fixed sum to a group (*au forfait global*), or by a fixed amount as a salary without

regard to the service given. As to other modes of payment of the physician, such as according to the medical act, or according to the number of insured on the physician's list, whether payment is by the society (third party payment), or by the patient (direct payment) it is necessary to leave the choice to each nation, according to the desires of each professional medical group, which thus follows the customs of each national collectivity.<sup>71</sup>

XV. The *administrative control* of the patients should be conducted by the care of the societies. The *professional medical control* should be exercised by the physicians, or by the medical councils approved by the societies in agreement with the medical group. The *technical control*, wherever it is indispensable, may be exercised only by a physician, under the form of a consultation between confrères, permitting the treating physician to explain his position with complete frankness and freedom and with perfect equality.

But it is to be emphasized that the physicians charged with the control of sickness insurance can successfully fulfil their rôle only if they possess the confidence of the treating physician, if they have an extensive experience with the problems of social medicine, and if they show great tact in the exercise of their functions. Moreover, only these qualities will assure them that cordial cooperation which is legally due them from the practicing physicians.

XVI. On the subject of legal control of professional relations the International Professional Association of Physicians is of the opinion that, since certain countries have established "medical institutions," charged with supervision of such work of the physicians engaged in insurance practice as deals with certificates of incapacity for work, economical prescribing, furnishing special appliances, etc., these institutions ought to be chosen in agreement with the professional medical groups and be sufficiently independent of the insurance organizations to be able to base their decisions exclusively on technical considerations. The participation of laymen in this work of control is not acceptable, since their decisions would lack technical judgment.

71. All of the sections in the text were adopted unanimously. The section which follows failed to receive a unanimous vote, as Dr. Cox of the British Medical Association expressly declared that he voted against it: "Direct payment of the physician by the patient guarantees a healthy and moral practice of medicine and tends to be extended little by little in the countries having systems of sickness insurance. The insured and the physicians who have lived for decades under a régime of payment through a third party may not always pass to this new method of paying medical honorariums, without a slow and methodical preliminary preparation of the public mind, which will be all the more necessary in those countries where the grave results of the world crisis cause especial resistance to the sudden introduction of any change, and it is the opinion of the General Council of the International Professional Association of Physicians that a disturbance of the relations between patients and physicians might aggravate the social sickness."

XVII. The better the administration of the society is organized from the medical points of view, the more useful and effective will be the medical service supplied to the insured. To secure this object, in the special interest of the patients, the International Professional Association of Physicians believes it to be natural and equitable that whatever is related to the medical service should be studied and regulated in agreements between the societies and the delegates of the medical groups. It follows that the medical corps should be represented in all phases of the administration that affect medical service.

The International Professional Association of Physicians declares that the insurance societies should act only as *intermediaries* between the patients and the physicians, pharmacists, hospitals, clinics, dispensaries, sanatoriums and preventoriums, but that they ought not themselves to operate either the factories producing pharmaceuticals, nor the hospitals, dispensaries, sanatoriums, preventoriums, etc.

XVIII. For all disputes and litigation, whether between society and physician or between the insured and the physician, there should be established special tribunals in which the interests of the disputants are equally represented, with the right of appeal, either to a special higher jurisdiction or to the ordinary tribunals.

XIX. The International Professional Association of Physicians approves the equal representation of employers, insured and physicians in the institutions of sickness insurance wherever these deal with questions of a medical character.

The International Professional Association of Physicians maintains in the very interest of social insurance that not only those who contribute by their payments should participate in the administration of social insurance, but also those who by their work assure not simply the operation, but the very existence of these institutions.

#### CONCLUSION

The International Professional Association of Physicians has kept in view, not only the professional and ethical interests of the physicians, but, above all, the interests of the sick, all of whom should, whether rich or poor, be assured of receiving the best of care.

That the representatives of the insurance societies should respect the rightful interests of the physicians, as well as those of the patients, and that the physicians respect, along with the interests of the patients, the rightful interests of the insurance societies, constitute the indispensable conditions for any proper solution of the problem of sickness insurance.



## CHAPTER V

SOME GENERAL PROFESSIONAL AND  
SOCIAL EFFECTS

It has already been noted that sickness insurance is one phase of the final results of the tendency of an industrial civilization to force a recalcitrant profession into industrial patterns. The "status" of a profession is to be destroyed by placing its members in the "contract" relation of employees of an industrial organization which will distribute medical services according to commercial principles. The personal relation of patient and physician is to be supplanted by a purely "cash nexus," such as now forms the only connection between the purchaser and the producer of shoes, clothing, food and other commodities.

This means the destruction of the essentials of professional life. Therefore every profession has resisted, with all its strength, every such effort to force it to follow the evolution of industry. Not alone physicians but lawyers, artists, the clergy, architects and all members of professions have insisted that there are certain conditions involved in professional status which, if destroyed, also destroy the value of the profession's services and its contribution to society.

Among these essentials of professional status are control of its standards of preparation, work and ethics by a professional association, the unrestricted right of each individual to exercise his own judgment as to his work within the limits of professional and legal control, and the maintenance of personal relations between the member of the profession and those whom he serves.

That certain evils have sometimes followed the exercise of this individual liberty in all professions is freely admitted. These evils are generally due to invasions of commercialism and relaxation of professional control. They are aggravated by every additional effort to substitute commercial for professional control.

These standards have been maintained by some of the professions for many centuries through various transformations in the industrial, political and social environment. Whenever one of these environments has succeeded in destroying these standards, not only the profession but also the society in need of the professional services has suffered.

Those who are advocating schemes of sickness insurance will at once deny that any such attack on the professional status is contemplated. There is no need to impute insincerity to this denial in order to prove its inaccuracy. It is just because broad social reactions are largely unconscious that they are so irresistible. The proof that this is the real intent and will be the ultimate effect, unless the efforts of those who are seeking to direct professional effort into industrial and commercial channels of evolution are defeated by the resistance of the professions, is found in the results already attained and in the frankly avowed position of the administrators of established systems of insurance.

There is an "International Conference of National Unions of Mutual Societies and Sickness Insurance Societies," which includes the carriers of sickness insurance for nearly 100,000,000 insured and dependents in all the principal European nations. This organization, like the International Association of Physicians, has issued statements of its official position. At its fourth general assembly, held in Dresden, Oct. 19-22, 1930, it adopted a report on "Methods of Controlling the Medical Service in Sickness Insurance," from which the following extracts are taken: <sup>72</sup>

It is not the insured patient but the *insurance institution which supports the cost of medical treatment*. Sickness insurance has, to a certain extent, broken up the complex of relations previously existing between the patient and the physician in the economic field. The economic relations existing between the practitioner and the patient are, however, not completely abolished but find themselves reestablished on another plane, since the insured patient may pay dues into the insurance institution for a long time before he calls for medical assistance. He thus pays the cost of his own treatment the same as a private patient, but he does not do this directly but instead furnishes his payment indirectly. The result is that the insured does not feel during his sickness the same worry which the noninsured feels, even the most prosperous, perhaps unconsciously, when he asks for the services of a doctor.

From the economic point of view the free practitioner is a *small business man (petit exploitant)* who freely exercises his profession in his own locality with the aid of the means of production which he possesses. This economic liberty has been always greatly restricted by instructions, principles and regulations established by the state, medical organization, etc. The

72. *Compte Rendu*, pp. 168, et seq. (italics in original). Jauniaux, A.: *Cent Années de Mutualité en Belgique*, pp. 100 et seq.

free practitioner is then, in most cases, not a free little business man in the original sense of the term, but is an artisan in his home.

The free practitioner can rise above this economic standard only if he becomes a "medical entrepreneur" possessing a large or small institution employing a more or less numerous body of wage workers. It is true that the doctor controlling insufficient economic resources may extend his clientele. But he cannot change the method of his exploitation. The difference between the free practitioner working alone and the proprietor of a medical institute with a certain personnel consists in the extent of his exploitation but not in its form.

The free practitioner is in a measure replacing the small exploitation by the large, through the method of combining the services of several confrères on a cooperative base. This form of medical practice is, however, very rare.

A genuine great exploitation, according to modern economic conceptions, is, as a rule, possible only if it is supported by corporations, especially by insurance institutions. These exploitations, which take the form of establishments applying definite curative methods, such as dispensaries and clinics, do not, in principle, recognize the free practitioner. The doctors working in these exploitations are, as a general rule, employees, and it is of no importance if they also carry on a private practice.

If we examine the advantage of the two systems from the point of view of the patient and the insurance institution it seems *indisputable* that the *great medical exploitation with hired doctors is clearly superior*. In the first place it shares all the advantages common to all great exploitations: better utilization of equipment, better division of work, economic security for employees and the possibility given to a doctor of getting rid of all material cares and of directing all his attention to the patient, etc.

The collaboration of several doctors, including specialists in the various fields, makes it possible in the beginning to diagnose the disease more rapidly and more accurately, to increase the knowledge of each practitioner, to direct the patient to the most appropriate treatment, etc. The collaboration of several practitioners also involves a permanent control of the professional work of the doctor. The chief doctor in a center of treatment constantly watches the work of his assistants, who, in turn, exercise a control on the orders given by the chief doctor. Even the auxiliary medical personnel exercise a certain surveillance, of which it is not necessary to exaggerate the importance. Finally, the *employed doctor is independent of the patient*. He can apply the treatments according to his scientific conceptions and to the extent of his medical knowledge, without considering the purely subjective desires of the patient, which may in no way correspond to the demands of medical science.

These same advantages are not found in the small medical exploitation. As these small exploitations are far the most numerous, and as there is no reason to expect their abolition in the immediate future, it is necessary to secure the advantages of the great exploitation while using the small. The strict enforcement of the rules of economical treatment which may be obtained by a serious control of the medical service of the societies is insisted on in order to get rid of at least a part of the inconveniences of the small exploitation.

This statement deserves some analysis and comment. The calm assumption in the first sentence that the "cost of medical treatment" is supported by the "insurance institution" perfectly illustrates the tendency, previously discussed, of an institution to develop its own personality and interests independent of, and even hostile to, its members who create and support it. The resulting effects on the insured member of being relieved of his "worry" have also been considered. It is also to be noted that the treatment is to be conducted "without considering the purely subjective desires of the patient." He is to form the impersonal material of the medical industry.

The demand for the complete industrialization of medical practice is set forth as the aim of insurance in a bolder form than most of the critics of such insurance have ever assumed to be the objective of its advocates.

At the same meeting Karl Scheck, director of the Insurance Societies of Upper Austria, maintained that sickness records should be kept in the society office and not be open to the practicing, but only to the controlling, physician.<sup>73</sup>

It may be replied that these statements express only the attitudes and objectives of the carriers and that they need not be accepted in the organization of any system of sickness insurance. But they are backed by far stronger forces. The International Labor Office is undoubtedly the most powerful propagandist of compulsory sickness insurance. It was instructed to act in that capacity by its governing body, the International Labor Conference, at its tenth session, in July 1927. This body is composed of the representatives of the various governments belonging to the League of Nations and also of the labor and employer organizations of these countries. No physician is a representa-

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73. *Compte Rendu*, pp. 67-68.

tive. At this session a "Draft Convention" was adopted, which has become the guiding program of the International Labor Office and the affiliated nations. One of the clauses of the section on "Organization" of this Convention reads: <sup>74</sup>

Among the *fundamental principles* . . . are that sickness insurance should be administered by self-governing institutions, that such institutions should be under the supervision of the public authorities, that the institutions should not be carried on with a view of profit, and that the insured persons should take part in the management of the self-governing institutions and should have at least half of the voting power on their managing bodies.

Quotations already given from recent statements of official representatives of the International Labor Office show that this policy of reducing members of the medical profession to the contract relation of supervised employees of law-governed insurance institutions is still maintained by that central organization.

Those who are urging a reorganization of medical service along insurance lines in the United States may say that since this country is not a member of the League of Nations there is no need to follow these policies. The reply is that a study of the representative statements in support of insurance schemes here shows the same attitude. The majority report of the Committee on the Costs of Medical Care and the writings in support of sickness insurance schemes show the same desire to develop the "large exploitation" of medical practice through groups, medical centers, clinics and insurance, and the same tendency to place the control of such institutions under lay management. The whole history of industrial and contract practice, both within and without the system of workmen's compensation, repeats the story. Everywhere there is the same tendency to destroy professional status and personal contacts between producers and consumers of professional service, and to substitute the contract relations of a lay employer hiring physicians supplying an impersonal market.

Unless all professional experience and professional opinion in the past have been wrong, it is the duty of the medical profession to oppose this tendency with all its resources if it is to preserve the standards of medical

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74. Official Report of Proceedings, p. 279.

ethics, scientific impartiality and personal sympathy that are the essentials of good medical service. If any system of sickness insurance is ever introduced in the United States, its general social effects will depend in a large degree on the success of the profession in resisting these tendencies of the present advocates of such insurance.

While the objective is seldom definitely stated by American proponents of sickness insurance, it must never be forgotten that the original purpose of such insurance was to relieve the poverty caused by sickness in families with insufficient wages and that this purpose still, even if unconsciously, dominates most of the activity in its behalf. Those who are most active in its advocacy are employers who pay these insufficient wages and philanthropists and social workers who are concerned almost wholly with relieving the evils of poverty.

There is no question of the tremendous importance of the problem of poverty in relation to sickness or of the great necessity of relieving it. There are many questions about the place of sickness insurance for the cure or alleviation of poverty. It may be at once admitted that insurance helps to spread the burden of sickness among all those with insufficient incomes who are insured. If, as is usually the case, the average income is below the standard required for a healthful existence, the payments for insurance may reduce that standard of living still further.

If, as in Germany, over \$300,000,000 annually is expended through the channels of the regular insurance administration, it may prove so great a burden on the whole class as to deprive the insured of many things more necessary to health than the sort of medical service received. While there is no intention of entering into a discussion of the merits or demerits of the whole system of social insurance as a means of relieving poverty, the tendency to exaggerated expansion of such systems is raising some very serious questions in Germany.<sup>75</sup>

The sum of all of these contributions that a laborer meets in the course of his life or is met for him is tremendous. It amounts to 15 to 17 per cent of his income. According to the calculation of Hartz, a laborer with a weekly wage of 36 M. in the course of a year contributed 260 M. Calculated at com-

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75. Kreschner, M.: Zur Praxis der Begutachtung, 1931, p. 11.

pound interest, he pays during his life, from 21 to 60 years, enough to create a capital of 33,000 M (about \$8,000). For a miner with a weekly wage of 60 M. (\$14) who is required to make social contributions of 27 per cent of his wages, this amounts to 16 M. weekly and 850 M. annually. It amounts from 21 to 60 years of age, with interest to a capital of over 100,000 M. (\$24,000). He could easily live on the interest of his capital after reaching 50 years of age and leave the capital to his children, who would then be raised to the envied position of a comfortable middle-class family. Our social legislation, however, simply takes this money away and compels the insured to work until he is 60 years old and then to content himself with a very small pension and to leave his children in the class of propertyless proletarians.

It is not simply that much of the burden of sickness and medical service for an unfortunate minority is spread over a whole class that is least able to bear additional burdens, with some possible relief of the resources of private philanthropy and public poor relief, but the medical service is also "spread," as has been shown, over a great body of insured who have no real need for it. In fact, there are many examples that indicate that the service is spread so thin that it is of little value to those who really need it.

It is impossible to obtain complete and accurate figures of the total cost of sickness insurance in any country. It is easy to get totals of the operation of certain phases of the system, which show that over \$300,000,000 in Germany and over \$160,000,000 in England and corresponding amounts in other countries are expended annually through the channels of the regular insurance administration. But these sums take no account of the great amounts that are spent indirectly in local and national subsidies through reduced charges for hospitalization, laboratory service and so on as well as for administration expenses not directly charged to the insurance accounts. In Denmark, for example, the insured are hospitalized at almost nominal rates.<sup>76</sup>

The first effect of nearly every effort to organize medical services with the objective of reducing the cost of medical care is to divert a considerable percentage of the money collected to the cost of management. Of course, if that management is so efficient as to accomplish more with the remainder than the entire sum would have accomplished without organization, there

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76. Newsholme: *International Studies*, volume I, p. 56.

is a positive gain. Systems of sickness insurance are too complex to permit any such analysis as would prove whether such efficiency exists or not. It is noteworthy that in Germany while the average cost of administration in recent years has been a little over 9 per cent, in some societies it reaches as high as 18.4 per cent and in one case, at least, is more than the amount paid to the physicians.<sup>77</sup>

Some idea of the social effects of insurance may perhaps be gained from the degree of satisfaction with its workings in the different countries. This is, of course, an extremely difficult thing to measure, but there are a number of signs that help in judging the degree of satisfaction. First of all, it is true that in no country with a system of compulsory health insurance is there any movement, with any prospect of success, demanding the abolition of the system.<sup>78</sup> There seems to be fairly general agreement, even among the sharpest critics of the system, that it offers some improvement in regard to certain preinsurance conditions.

There are numerous considerations that prevent the acceptance of these facts as indicating general satisfaction. In most countries the insurance societies have such great political power (which does not always reflect the sentiments of their members) and the possibilities of purchasing votes through insurance benefits are so attractive to the politician as to make it almost impossible to organize any movement for the abolition of insurance.<sup>79</sup> Furthermore, provisions for medical

77. *Aerztliche Mitteilungen*, Feb. 13, 1932, p. 130. See also Report of British Ministry of Health, 1930, p. 267.

78. G. F. McCleary (*National Health Insurance*, p. 15) points out that recent opposition in France, especially among agriculturists, indicates that this generalization may require some modification.

79. Lick, E.: *Soziale Versicherungen und Soziale Gesundheit*, pp. 63-64, lists three reasons why in spite of such dissatisfaction there is so little open hostility to sickness insurance in Germany: (1) the political situation; (2) the large number of the population dependent on the system ("the 70,000 employees of social insurance are not going to saw off the limb on which they are sitting"); (3) lack of "civil courage" to attack a national institution that has been so long pointed to as an example of "social thinking."

While Dr. Lick is perhaps the best known critic of the insurance system, it must be noted that he is not to be considered as an absolute antagonist of the principle of social insurance. In an article in the *Schweizerische Medizinische Wochenschrift*, May 17, 1930, pp. 466-471, which as a whole is an attack on insurance, he says:

"If, without prejudice, we consider this evidence, we must first of all firmly maintain: The idea of social insurance was preeminently worthy of a great civilization, a road that must, under all conditions, have been entered upon. There are still many old doctors among us who lived in the old uninsured days; they paint the conditions with shudders. How often did a long sickness or a serious accident to the supporter bring the whole family to despair and the bitterest necessity! I myself have not outlived the echoes of this time. It was not until the beginning of the present century that the agricultural laborers were protected against sickness and disease."



care for the underpaid previous to insurance in most countries were far worse than exist at present in the modern nations without such systems. There was, for example, no such extension of public and private medical facilities for this class as exists in the United States. The situation that prevailed in Great Britain was far more typical. Here there were a host of voluntary insurance schemes that degraded the medical profession and provided a most unsatisfactory service.

The Majority Report of the Committee on the Costs of Medical Care, which recommends sickness insurance, says: <sup>80</sup> "It is probably true that in the United States, except for some rural areas, a much larger amount of medical service is available, and is actually obtained, even by low-wage-earners, than was the case in any European country during the period when its health insurance system was developing." Under such conditions as prevailed in these European countries, almost any change was an improvement.

The International Association of Physicians sent out an elaborate questionnaire on the workings of sickness insurance and published the replies in its *Revue Internationale* in August 1931. Each medical association was asked to express an opinion as to whether the system of sickness insurance in its country was generally satisfactory to the insured and to the physicians. The replies are given in the last two columns of table 3.

Reports were received from nineteen nations. Only four of these stated that the system was generally satisfactory to both the insured and the physicians: Bulgaria, Denmark, Great Britain and Holland. In the last named country, insurance applies only to industrial accidents. In France and Sweden the physicians were reported to be satisfied but not the insured. In November 1932 the Bulgarian Medical Association reported that the societies had succeeded in changing the law so as to destroy free choice of physicians and permit the societies to give medical service almost exclusively through medical institutions such as clinics and dispensaries with salaried physicians.<sup>81</sup> A bitter fight followed with all the customary effects on service.

The distinguishing character of the two generally satisfactory systems—British and Danish—is that these

80. Publication 28, p. 128.

81. *Revue Internationale*, November 1932, pp. 101-102.

are the only ones of long standing in which there is the *least* lay control of medical service, and where the professional associations play a dominating part. As has already been noted, the Danish system has since been changed from a nominally voluntary to a completely compulsory system, and no word has been received as to the effect of this change on the degree of satisfaction of the insured or the physicians.

Another test of satisfaction is gained from a study of the mass of discussion, and criticisms in the various countries. Here again interpretations and definite conclusions are difficult, but it is certainly true that critics are the most prolific writers. Such writings are a seething mass of condemnation, criticism and demands for far-reaching changes in existing systems. Even in Great Britain there have been repeated investigations by royal commissions and parliamentary committees, which have recommended fundamental alterations in the system, including the suggestion that the "Approved Societies" be entirely divorced from the scheme.<sup>82</sup>

The evolution of sickness insurance to its present position, with some of the consequent changes, has been traced. But, as has also been noted, that evolution shows no signs of stopping. On the contrary, every system is continuously considering important changes.

One proposal is so fundamental and has been so strongly urged in so many countries that it deserves special consideration as indicating the degree of dissatisfaction, and a tendency to reverse some previous lines of evolution. From many sources comes the demand that the attempt to distribute the whole burden of medical care and relief during sickness be abandoned in favor of a return to individual responsibility for a portion at least of that burden.

The Swedish, Norwegian, French and Chilean systems have always required the insured to bear a portion of the burden when the service is given. In Denmark, Switzerland and Luxemburg only a part of the cost of drugs is paid by the insurance system. It is noteworthy that complaints of excessive practice and overmedication are seldom heard in these countries and that they

82. See comments of Sir Henry Brackenbury in Supplement to British Medical Journal, July 15, 1933, pp. 25-26, where he raises questions as to the success of the British Health Insurance in meeting its objectives. See also A. M. A. Bulletin, November 1933, pp. 120-122, where Sir Henry Brackenbury's statements are reproduced and discussed.

have not shown any such alarming increase in "morbidity" as has characterized other systems.

It would not be fair to instance the charge of 12 cents for each illness and a similar amount for prescriptions, provided by the "emergency degree" in Germany as being motivated by an intention to reform sickness insurance in this direction, although the action was justified by some of its defenders on the ground of compelling the insured to share immediate burdens. The main object was undoubtedly economy, but its unexpected effects on "morbidity" have raised a flood of discussion involving some of the basic principles of insurance.

A far greater impulse in the direction of limiting the distribution of the burden to a portion of the expense of sickness has been supplied by the system of private sickness insurance, which has grown very fast in Germany since the war and which now has more than three million members.<sup>83</sup>

The success of these schemes seems to rest on three principles: first, they apply only to catastrophic and not to minor sicknesses; second, they pay only a certain percentage of the cost of any sickness; third, they fix a maximum amount that will be paid in any case.<sup>84</sup> The amount paid is usually between 70 and 80 per cent of the cost of medical service, according to a fee schedule. The insured go to any physician they choose and deal with him exactly as in private practice, or under the French system, and then receive a percentage of the fixed fee from the insurance company. This plan has by no means furnished a "solution" of the problems of sickness insurance. It is still selective. Its limit of care (usually for twenty-six days in one year and thirteen days in the succeeding year) leaves many painful cases of suffering to be cared for in other ways. Its scope is necessarily confined largely to those with at least fairly high incomes as compared with the mass of wage workers. It has, however, suggested and strengthened some proposals as to lines of possible better development of insurance.

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83. Zillessen: Die private Krankenversicherung und ihre Beziehungen zum Arzt, 1930, p. 5. Finkenrath Kurt: Krankenhilfe und Gesundheitsfürsorge durch die Aerzteschaft, p. 93 et. seq.

84. Zillessen: Die private Krankenversicherung und ihre Beziehungen zum Arzt, pp. 12-13.

A large number of German writers, apparently with a considerable following (at least until the Nazi revolution) are urging the substitution of some form of compulsory saving or other plan by which there will be less of a general distribution of the burden and more individual responsibility, while at the same time retaining sufficient of the features of the present system to relieve the excessive burdens that now fall on individuals with catastrophic sicknesses. It is now coming to be recognized not only that the whole subject of sickness insurance is so almost inconceivably complex and involves such a multitude of uncertain social and personal factors that experiments should be preceded by far more investigation than has hitherto preceded action, but that even after such investigation progress must still be largely by trial and error.

In Germany, and also in some other countries with long experience with compulsory insurance, there is a strong movement, especially among physicians (although by no means confined to them) in favor of some sort of compulsory system of saving as a substitute for insurance as at present operated.<sup>85</sup>

There is considerable variation in the details of the proposals of these various writers, but all involve the principle of segregation of all or part of the contributions of the insured and of returning a certain portion at death or at the age when an old age pension is granted or else to offer a cash reward or suspension of contributions to those who have not asked the aid of the fund for a certain period. A similar plan has been vigorously urged by P. Specklin, a physician with a

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85. Hartz, G.: *Neue Wege in der Sozialpolitik*, 1929. Müller Arthur: *Zwangssparsystem statt Sozialversicherung*, 1929. Liek, Erwin: *Soziale Versicherungen und Volksgesundheit*, 1929. Zeisler, August: *Im Kampf gegen Vergewaltigung durch den Staat*, 1931. Hartz, Gustav: *Eigentum oder Rente*, 1930. Baeumer, Waldemar: *Die Krankenversicherung, Jetzt ein Fluch umgestaltet ein Segen für das Volk*, 1930. The intentions of the Nazi government were outlined by Hadenkamp in the *Aerztliche Mitteilungen*, March 11, 1933, pp. 223-225, where he says concerning this phase of the subject: "The exact form that this fundamental reform will take cannot be stated today. A certain rôle will be played by the idea of directing insurance into a compulsory savings system. As is well known, this idea has for a long time been active in the public mind and has been discussed by the medical profession. In medical circles it has been differently estimated; some have welcomed it strongly. . . . The national socialist movement has declared itself for the development of the idea of saving but has coupled this with the proposal for fundamental changes. State Secretary Dr. Krohn in an interview with the representative of a great daily paper has declared that he saw possibilities in a sound combination of insurance and savings. He thought—and that is important for us—to be sure only of the cash insurance, not of sickness insurance."

long prewar experience under the German system at Mulhouse.<sup>86</sup>

The demand of the medical associations that the insured be individually required to meet some share of the medical expense at the time it is incurred is receiving such wide support that, in spite of the opposition of the societies, it has a good prospect of adoption into several of the older systems and will probably be incorporated into any that may be established in the future.

There would thus appear to be a general reaction against such an excessive distribution of the burden of sickness as so completely to destroy the sense of individual responsibility that, as a final result, the total burden is greatly increased.

This raises the hotly debated question of whether insurance is suitable to meeting the risk of sickness. Like most disputes, this tends in part to be a question of definition. If insurance is defined simply as a means of distributing costs, it becomes almost synonymous with taxation and can be made to cover almost any form of expenditures. But if the meaning is to be confined to a method of meeting risks which are beyond the control of the individual but which can be accurately calculated for a large number of cases and the risk distributed according to that calculation, it is highly questionable whether the insurance principle can properly and successfully be applied to the costs of sickness.

These conditions apply to fire, death, old age, shipwreck, storm, accidents and numerous other risks against which insurance has long been successfully applied. These are the causes of exceptional losses, seldom desired by the individual on whom they first fall, and are susceptible of sharp definition and definite cash appraisal. But the whole experience of sickness has proved that sickness is an indefinable condition, frequently desired by the insured individual, and therefore created in part by insurance itself. Its compensation in terms of medical service is almost incalculable. Its incidence is so much due to subjective causes that all actuarial tables regarding it have been proved valueless. The British system was founded on

<sup>86</sup>. *Presse médicale*, Feb. 26 and March 6, 1919; also in *British Medical Journal*, January 25, 1930, supplement, pp. 25-28. See also McCleary, G. F.: *National Health Insurance*, 1932, pp. 157-159. For similar movement in Austria see Augustin, Gisela: *Klinische Wochenschrift*, Feb. 13, 1932.

the use of one of the most extensive tabulations ever prepared, yet in less than twenty years those tables were found to have reckoned the risk at only about one-half what was actually encountered under the operation of a nation-wide compulsory system. Data already quoted have shown that "morbidity" risks under insurance vary far more according to the wishes, interests and attitude of the insured than according to any pathologic conditions.<sup>87</sup>

There are no standards by which to calculate the cost of treatment. Statistics on the average number of visits and drugs required per patient year, so meticulously and expensively collected by industrially and commercially minded lay administrators in many systems, are of little practical value. None of these standards of required service are based on a yardstick that measures the "will to get well," which is today the decisive factor in determining "morbidity" as well as treatment statistics. Neither do they measure the attitudes of the physician; yet these are most important factors. Averages are altogether deceptive, because they cannot be adjusted for the most important element in their variations. It has already been shown that such variations are due far more to the effect of industrial and economic changes on the emotions and desires of the insured than to any recognized pathologic conditions.

Efforts to measure the value of a physician's services by a time clock and medical treatment by averaging the price of prescriptions are only monotonous repetitions of the foolishness of applying the standards of commodity markets to the application of medical or other professional services. Some advocates of sickness insurance have tried to meet this logical dilemma by comparing medical service under sickness insurance to

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87. "Enough has not been made of the fact that the actuarial basis of the National Insurance Act is all wrong. It was based on the sickness statistics of the old friendly societies, which were altogether different from the present conditions. There was nothing at all approaching the present sickness among the old members of friendly societies; there is twice the amount of work now. They were all picked members, the funds belonged to the members, and they felt a personal interest in them. If a member thought another was staying on too long he would soon report it to the secretary, who regarded it as confidential information and acted on it. As Dr. Cox told the societies at the meeting at Ramsgate, it is the altered outlook of the members that is the cause of increased claims, and not the doctors' certificates. If some of our leaders would speak out as plainly as he did, people would respect the profession more. By a quiet acquiescence and neglect to hit back people think we are in the wrong." Arthur E. Larking, M.D., *British Medical Journal*, Nov. 7, 1931, supplement, p. 266. See also Rappleye, W. C.: *Pennsylvania Medical Journal*, May, 1933, p. 602. Report of Royal Commission on National Health Insurance, 1926, Appendix A.

repair service under automobile insurance. The comparison further illustrates the original logical confusion. Human beings are not machines; physicians are not mechanics who can always give an accurate diagnosis, and there is no supply of spare parts with which to make repairs. At every stage of the automobile example, cash standards are readily available for us; they are absent at every stage of sickness insurance.

All this does not prove that there is no need for appropriate arrangements to assist low income classes in meeting the unequal burden of medical care, but the facts cited do seem to justify the conclusion that all schemes developed by laymen from patterns formed by an industrial and commercial environment have made small contributions to the solution of that problem. Whatever progress has been made toward a solution has been made through the efforts of professional associations, and generally through a bitter fight with lay administrators.

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