

Handbook
State Medical
of Medicine

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PREFACE

The American Medical Association presents herewith, for those who are especially interested in reading in the field of medical economics, a number of abstracts of articles on health insurance, state medicine and the cost of medical care published during the past five or ten years in various publications. The abstracts have been prepared by the Bureau of Medical Economics and the abstracting department of *The Journal of the American Medical Association*.

INTRODUCTION

In the selection of books and articles to be summarized, an effort has been made to consider impartiality, accessibility and diversity of information, and no attempt has been made to present a complete bibliography. Such a bibliography would include hundreds of titles for almost every system, and thousands for some of the older and most frequently discussed.

Preference in selection has been given to works dealing with medical service and to professional and patient relations under insurance. There are many official and semiofficial documents in all insurance countries and the insurance carriers publish a mass of reports, journals and other material, all of which must be consulted in any thorough study of the subject. Such publications are accessible in so few localities that generally they have not been included, nor can they in most instances be satisfactorily summarized.

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Handbook on Sickness Insurance, State Medicine and the Cost of Medical Care

INCIDENCE OF ILLNESS

AMERICAN MEDICAL ASSOCIATION: THE EXTENT OF ILLNESS IN THE UNITED STATES, editorial, J. A. M. A. **93**: 1810 (Dec. 7) 1929.

A wide variety of views is offered regarding the problems of the medical profession in relation to the public. The adequacy of existing curative and preventive medical services and their effectiveness are being questioned. To these problems the Committee on the Cost of Medical Care is giving careful consideration. It has become imperative to secure facts lest a tragedy of errors supervene. The Commission on Medical Education, organized under the leadership of President Lowell of Harvard University, has already reported an extensive study of the demands and needs for medical service, in part by sampling the demands on general practitioners in communities small enough to give a clear picture of general practice. The preliminary surveys indicated that about 75 per cent of the office visits were for minor surgery, upper respiratory infections and general medical and venereal diseases. About 90 per cent of home visits were for infections of the respiratory tract, general medical and contagious diseases, obstetrics and minor surgery. More than 90 per cent of the illnesses are of types that cannot be controlled on a community basis but are problems of individual patients. Less than 10 per cent are diseases against which public health efforts are mainly directed. This fact is an index of the growing efficiency of public health efforts and emphasizes the necessity of treating the patient as well as the disease. The common causes of disabling illnesses and absenteeism correspond closely with 80 per cent of the combined office and home visits of the general practitioner. The dullness of ordinary statistics is lost in some of the discoveries of the Committee on the Cost of Medical Care. They indicate for this country that people are, on the average, disabled by illness at least once annually, men about once a year, women from once to twice, and children more than twice each school year (of 180 days). On the basis of the lowest rate for disabling illness found by the United States Public Health Service, there would be about 130,000,000 cases of disabling illness in the United States each year and, if nondisabling illnesses should be added,

this figure would be more than doubled. What this may mean is indicated by the conclusion that the 36,000,000 wage earners in the United States lose at least 250,000,000 work days a year and the 24,000,000 school children 170,000,000 days each school year. These figures take into account only half of the total population. Numerous surveys have indicated that colds and bronchial conditions, and influenza and grip, are obviously the most serious causes of disability from the standpoint both of frequency and of days lost. On the basis of both the number of cases and the total time lost, digestive diseases and disorders loom large. Diseases of the pharynx, tonsil and larynx—including adenoids, tonsillitis, sore throat and croup—are also of considerable frequency and severity. The nonvenereal diseases of the genito-urinary system and adnexa receive prominence in the list, largely because of the frequency of cases of dysmenorrhea among women and girls; but included are acute and chronic kidney diseases, which each year cause an increasing percentage of the total mortality. It may not be an agreeable reminder, but the medical profession must nevertheless face the warning that in 1928 there were nearly 2,000,000 births in the registration area, many of them followed by complications and a considerable number (a larger proportion than in most civilized countries), by death. On the other hand, the public and particularly a small obstructive group of antivaccinationists should properly bear much of the odium of more than 36,000 cases of smallpox reported in a recent year. According to these complications, special estimates place the number of persons in the United States who are mentally defective, (feeble-minded, imbeciles and idiots) at more than 900,000; the number of blind at more than 100,000; the number with major speech defects at 1,000,000, and the number of school children wholly or partly deaf at 3,000,000. This country is by no means oblivious of the great problems here presented. There are in the United States more physicians per thousand people than in any other country in the world. Hospital beds and clinics show rapid rates of increase, clinics having the most spectacular growth of all. Hospitals other than those for nervous and mental diseases contain, on an average, more than 350,000 patients at all times. The total in all hospitals on a single "average" day is about 700,000. Such striking figures, even with their admitted incompleteness, justify the reminder of Mills of an extent of illness and physical and mental defectiveness in the population which causes an incalculable amount of human suffering and economic loss. Some of these diseases and conditions, Mills adds, rob the nation's people of their vitality and destroy their efficiency; others lead to sudden death and the premature cutting off of life. This continuance of disease, part of it preventable, indicates a field for the more widespread and efficient utilization of preventive and curative measures now known.

AMERICAN MEDICAL ASSOCIATION: SICKNESS IN POVERTY,
editorial, J. A. M. A. 93:1227 (Oct. 19) 1929.

The impression prevails among practicing physicians that sickness is most common among those least able to afford it. Scientific and statistical confirmation of this belief is available in the latest report of the morbidity studies of the Public Health Service at Hagerstown, Md. Some 1,800 households visited in 1921 were classified according to economic status. The classification was checked by ten members of the research staff. Other members proceeded, during the following twenty-eight months, to make an inventory of all sickness occurring in these households. The illness rates, corrected for age, during this period were as follows: well-to-do, 991 per thousand; moderate, 1,068, and poor, 1,113. Analysis by age groups shows that these differences tend to disappear in adolescence and old age, being most marked in middle age. In early infancy the order of morbidity is reversed, the children of the wealthier parents suffering more sickness than those of the poor. A satisfactory explanation is not offered for this observation. From a study of the printed curves one gains the impression that it is a distinct advantage to be able to treat with proper respect and leisurely convalescence the acute disabilities of middle age, such as rheumatic, influenzal and respiratory infections. One aspect of the study gave quite definite results: "Those families which were definitely above the average of this community in economic condition had medical attention to a considerably greater extent than the remainder of the population."

**ARMSTRONG, DONALD B.: A STUDY OF SICKNESS COST AND
PRIVATE MEDICAL PRACTICE,** Metropolitan Life Insurance
Company, May 13, 1932.

Weekly reports from 30,965 employees of the Metropolitan Life Insurance Company were analyzed. There was an average of 3.9 individuals per family. The total group included over 120,000 people. This study is based on a tabulation of the reports of 8,677 families, or 33,796 persons. Some expense for sickness or injury during the year was reported by 94.5 per cent of the families. The total expenses reported was \$854,343, which was 3 per cent of the known total family incomes. The average sickness cost for all families audited was \$98.46, which represents \$25.25 per capita. The distribution of these expenses is shown in the table.

Expenses were highest in the Mountain and Pacific Coast sections and next highest in the Middle Atlantic states, including the metropolitan area of New York. The families with incomes of \$10,000 or over spent 1.8 per cent of their annual incomes for medical care. Families with \$2,000 or less spent 3.6 per cent.

Cost of Sickness and Injury in 8,677 Families. Metropolitan Life Insurance Company Field Survey, October 1930 to October 1931

Items	Aggregate Costs of Sickness and Injury	Percentage Each Item of Total	Average Cost per Family	Percentage of Annual Income
All expenditures.....	\$854,343	100.0	\$98.46	2.7
Doctor	340,019	39.8	39.19	1.1
Dentist	135,264	15.8	15.69	0.4
Nurse	38,833	4.6	4.48	0.1
Osteopath	4,396	0.5	0.51	0.01
Chiropractor	6,289	0.7	0.72	0.02
Eye—doctor and glasses.....	90,378	3.6	3.50	0.1
Other treatment.....	23,083	2.7	2.65	0.07
Drug store.....	110,319	12.9	12.71	0.4
Hospital or sanatorium.....	116,287	13.6	13.40	0.4
Clinic or dispensary.....	3,371	0.4	0.39	0.01
Extra household assistance....	32,124	3.8	3.70	0.1
Any other expense.....	14,030	1.6	1.62	0.05

The figures also indicate that if a collective purchase or reserve system for meeting medical charges should ever be experimented with, the average cost to be met for a family of four or five would appear to be in the neighborhood of \$100 to \$125 a year, for such services as are rendered at present, though whether or not they can be considered adequate, in relation to the needs or desires of family members, is another question.

DAVIS, M. M.: *THE BLUNDERBUSS OF SICKNESS*, Survey, Graphic Number, 59:435 (Jan. 1) 1928.

During 1922 a public health nurse under the auspices of the Committee on Dispensary Development followed intimately for seven months the health of the population of a single block on East Thirty-Ninth Street, New York City. Systematic reports of all illness were secured. Four hundred and thirty-six cases of illness were reported from an average population of 1,800 but these 436 cases occurred among 292 individuals, several of whom, as will be seen, were sick more than once. There were 400 families in the block. The 292 sick persons were in only 160 families, 40 per cent of the total. In 60 per cent of families no sickness was reported, though the statistics doubtless overstate the case, as there probably were unreported illnesses. Even with considerable allowance for such errors, the figures furnish a good illustration of the uneven incidence of sickness. The uneven incidence of expense follows inevitably. Of this much one may be sure, that no method will be found even for dealing with the financial burden—much less for the more complex problems of the professional service—if the effects of

sickness are measured merely by the hits of the blunderbuss or by the dollars required to keep up the repair shops. The impersonal data of sickness and of income and expenditure must be seen as they interplay with the standards and aspirations of the medical profession and with the contemporary standards of living, those intangible yet dominating compulsions which overlie the people's choices of modes of doctoring and all the habits and customs of family expenditure. The engineers who are to find a way out of the predicament must guide their path by the sign of the caduceus as well as of the dollar, and must breathe an atmosphere charged with human motives as well as arithmetic.

FALK, I. S.; KLEM, MARGARET C., AND SINAI, NATHAN: THE INCIDENCE OF ILLNESS AND THE RECEIPT AND COST OF MEDICAL CARE AMONG REPRESENTATIVE FAMILIES, The Committee on the Costs of Medical Care, 1933.

The definition of illness used as a basis of this study was:

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

The study covered 8,639 families with 38,668 individuals. They were surveyed for twelve consecutive months during 1928 to 1931. On the basis of the foregoing definition, it was discovered that from the lowest to the highest income groups, the incidence of sickness increases by 39 per cent, the rate of hospitalization by 87 per cent, physicians' calls by 145 per cent, dental cases by 651 per cent, refractions or glasses by 552 per cent, and health examinations by 333 per cent. There is a wide variation in charges for medical care. The average charge in the low income class is \$49 and the highest is \$503. Forty-seven per cent reported no illness during the year. The present problem in the cost of medical care devolves not from the average cost but from the variation in cost.

FINKENRATH, KURT: SICKNESS INSURANCE IN AUSTRIA, *Deutsche med. Wchnschr.* 32:1356 (Aug. 8) 1930.

This is a study of the krankenkassen of Steiermark and Kärnten in Graz, Austria, where the physicians are regularly employed, and includes specialists and dentists. Although the membership has been reduced in recent years, the number of medical services has continued to increase, as the accompanying table clearly shows.

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	30,528	61.35	7,676	15.42
1919	39,624	43,839	110.7	21,837	49.18	9,399	21.44
1920	46,340	54,725	118.0	28,969	52.99	14,441	26.39
1921	46,608	58,446	125.4	30,376	51.97	17,438	29.83
1922	45,500	64,321	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	36.90
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

Certain remarkable conclusions may be drawn from this table. The number of incapacitated for work has increased gradually and is about the same as is shown by the statistics of all other countries. There has been an extraordinary increase in the sicknesses that do not lead to incapacity for work. In 1918, 61.35 per cent of the cases of sickness were accompanied by incapacity for work, while in 1927 these amounted to only 42.1 per cent.

This comparison shows clearly that the number of bagatelle cases in sickness insurance have increased enormously and that the increase in the amount of service required is due to these cases. The demand for services in the case of dependents, which are given in the last two columns, shows this even more clearly. Of especial interest are the figures of the increase in the number of specialists' services that have been required in the system of employed physicians in Graz. The number of teeth filled has increased from 300 in 1919 to 1,135 in 1927. The number of violet ray treatments has increased from 651 in 1920 to 2,201 in 1927, and the number of roentgen treatments and photography have increased from 75 in 1920 to 1,334 in 1927. Unfortunately the report gives no figures concerning the increase in the costs of drugs. The number referred for further investigation as to ability to work increased from 17,300 in 1918 to 41,984 in 1927.

COSTS OF MEDICAL CARE

AMERICAN MEDICAL ASSOCIATION: THE COST OF MEDICAL CARE, editorial, J. A. M. A. 94:106 (Jan. 11) 1930.

The most recent publication of the Committee on the Cost of Medical Care concerns hospital service for patients of moderate means. Mr. Carpenter introduces his consideration with a realization of the fact that hospitals were first constructed for the poor and then provided rooms for the rich, and that only recently have institutions begun to adapt both structure and administration to the care of the middle class. The survey revealed that 121 hospitals out of 132, whose letters tell of future plans, include the provision of special facilities for patients of moderate means. Hospital rooms with service can now be had at prices varying from six dollars a day to as much as the patient cares to pay, these rates being after all about the same as for hotels; and the latter do not provide food. Nevertheless, a person who selects a middle class or low middle class hotel when he travels is likely to want the best of hospital accommodations when he is sick. Ward beds and semiprivate beds in rooms for two or four may be had for much smaller charges than single private rooms. However, associated with the charge for the room are such charges as laboratory, anesthetic, roentgen-ray, special nursing and operating room fees, for which the patient is usually not prepared and which serve not infrequently to bring his total bill to a sum that arouses consternation. Suggestions have been made for elimination or redistribution of such fees, charging them to the room charge or to the flat-rate operation or obstetric fee; but the whole matter of administration is still in an experimental stage.

CARPENTER, NILES: MEDICAL CARE FOR 15,000 WORKERS AND THEIR FAMILIES, The Committee on the Costs of Medical Care, Publication 5, 1930.

The estimated number of employees covered by this study was 15,230 in 1928. Medical service was established in 1916 and had grown to cover about 90 per cent of the workers in 1927. There is a full time staff consisting of twenty-eight physicians, four dentists, and the remainder secondary practitioners. All medical care is available without charge to employees. The cost per individual to whom the service was potentially available was \$21.81 per annum, and the cost per individual in families which actually used the service was \$25.49 per annum in 1928. No physician receives less than \$3,000 or more than \$12,000 a year. In some respects the service seems to be superior to the type of private practice

found in Binghamton and similar communities. In other respects it seems to be somewhat below the existing standards in other communities.

DAVIS, M. M.: DOCTORS' BILLS AND PEOPLE'S BILLIONS, *J. A. M. A.* 94:1014 (March 29) 1930.

Davis emphasizes that the figures and estimates of his paper are tentative and to be corrected, he hopes, through studies now under way by the Committee on the Cost of Medical Care. With this proviso, the following summary is presented: The annual outlay of people of the United States for the care and prevention of sickness is tentatively estimated as \$2,841,000,000. Doctors' bills make slightly less than 25 per cent of this total. Hospitals and clinics make 30 per cent; medicines and medical supplies 25 per cent. The expenditure for prevention of disease is only about one thirtieth of the total and is far too small as compared with the vast expenditure for cure. There are large wastes in the present expenditure, as for unnecessary drugs and medicines, for unscientific forms of treatment and for overhead and duplication of medical facilities. The public that purchases care in sickness must bear a share of the responsibility for the cost of medical care, because of poorly directed spending. The total of the sickness bill is only about one thirtieth of the national income. The source of complaint about sickness bills is not so much the amount as the manner of distribution. Sickness bills differ from nearly all other expenditures in the family budget because they occur with uncertainty and they fall unevenly. There is evidence that approximately half of the total sickness expenditure falls annually on about one sixth of the families in any given group. To solve the financial problem of sickness means in part the reduction of costs but in larger part the redistribution of burdens. Systematic arrangements for instalment payments of the larger sickness bills may be of some assistance in helping people to pay them. Insurance against sickness bills, particularly hospital care, should be developed on an experimental basis and separated as fully as possible from the complex issues of professional service.

DAVIS, M. M.: How PAY SICKNESS BILLS? Survey, *Graphic* Number, 60:541 (Sept. 1) 1928.

If the statistics thus far gathered about the cost of sickness and concerning family expenditures for its care mean anything at all, they demonstrate two truths which lie at the root of the financial problem of sickness and at the basis of its solution. First: Our spending habits for sickness are less

than our spending ability. An itemized estimate of all that individuals, organizations and governments in the United States spend for the care of sickness and the promotion of health leads to the conclusion that the sum total is about three billion dollars a year. This is some $3\frac{1}{4}$ per cent of our gross national income of ninety billions! Only about one hundred millions, or one thirtieth of the three billions, goes for preventive work. For cigarets alone we spend over a billion annually. Cutting down one tenth of our cigaret bill would provide for more than doubling the expenditure for preventive medicine. Second: It is the unevenness of the burden of sickness, not its total amount, which creates most of the present financial problems. Take a thousand city families with 5,000 members and with incomes a little above the self-support line—from \$2,000 to \$2,400 a year. The available statistics show that they will altogether expend from \$80,000 to \$100,000 a year for the care of sickness and that about 160 of the thousand families will have so much sickness that they must spend about half the whole amount—from \$40,000 to \$50,000—while on some 300 families illness falls so lightly that altogether they pay out less than \$10,000. With families of large income the expense figures will be larger; with smaller incomes they will be less; but always the expenditures will be highly uneven and always any particular family will be uncertain into which group—happy or unhappy—it will fall. The complex and intimate elements which permeate the professional aspect of the sickness problem render it impossible that any simple or universally applicable plan of simplifying and improving medical service, while at the same time reducing its cost, can be applied throughout this country on any machine-made or standardized scheme. Care in sickness is intimately personal. It touches deep emotions. It is not a field for wholesale dealing. Its problems are not to be solved by the panacea of some universal legislative scheme of state insurance nor by the panacea of keeping things as they are. Perhaps panaceas are useful as bogies to keep extremists busy and help other people to see the boundaries of the road. Three principles we may hold fast to: First, that medical care must be personal in order to be effective; second, that medical service must be organized in order to be either effective or economical; and, third, that the financial burden of sickness must be distributed if people are to escape either charity or neglect.

FOLLANSBEE, G. E.: A DOCTOR DIAGNOSES THE BILLS, Survey Graphic 16:375 (Jan.) 1930.

The complaint is made about the high cost of sickness. Is not the complaint actually about the high cost of health? When looked at in this way, the complaint sounds less reasonable. Health is as much of a necessity of life as shelter. One

can be happy without fur coats, radios, overstuffed furniture, automobiles, bootleg booze, vacuum sweepers and the score of unnecessary trifles that make life easier and more pleasant; but one cannot be happy without health. Perhaps health costs too much for people of moderate means to be able to pay for it what it is worth and what it should reasonably cost, but that proposition has not yet been demonstrated and cannot be until health is approached as a necessity of life, as are food, warmth, clothing and shelter. But better physicians cost more and are worth more. They cost more to make and they cost more to maintain. The expense of equipment for the modern practice of medicine and for keeping pace with medical progress is no small item in the physician's budget. To use a homely analogy, the medical schools and hospitals in response to public demand are turning out electrically operated vacuum sweeper physicians. Fifty years ago a fifteen to twenty-five cent broom was a satisfactory cleaner. Thirty-five years ago, families who could afford it paid from three to five dollars for a carpet sweeper. For the last few years all who can afford it (and many who cannot, as doctors can testify) have a fifty to seventy-five dollar vacuum cleaner. People want and need the efficient and expensive doctor; they want the expensive cleaner; but the doctor is a necessity and the vacuum sweeper a convenience. There is no question as to the choice between them should the need for both arise, but unfortunately salesmanship impresses the daily need for one while the need for the other is never impressed except by its arising. Consequently, provision is made for the one, but for the other a happy, optimistic wish and gamble that the need will not arise is apparently the only thought, if any, that is given to it. Instalment payments for insurance against sickness or periodic deposits in savings accounts for sickness are as much more obligatory, morally, than many instalment payments (that help, incidentally, to cause the cry against the cost of medical care) as the necessity for the one is greater than for the other. Such insurance or such savings accounts would do much to lessen the apparent need for relief. In cogitating on what persons spend for medical care, another expense which seems to have been overlooked is the amount paid to cultists, quacks and advertising fakes, most of it by the "great middle class." Unlike the doctor, they never temper their charges to the means of their patients, never wait for their pay or work for nothing, and the money paid to them is mostly thrown away, or worse. Without dilating on the paradox of a state compelling a college man to spend four years in expensive study, and in some states five, before he can legally treat the sick, and at the same time allowing any one who has graduated from a high school or has had an "education equal" to it, after a short course in some "college," also to treat all sickness provided he does not use drugs or provided he uses only manual manipulation, the physician wonders how much the excessive cost of medical care would be reduced if these parasites were exterminated.

GEISTER, JANET M.: THE HIGH COST OF NURSING, Survey Graphic 16:426 (Jan.) 1930.

The tradition of providing continuous nursing service to every patient, with a nurse at the bedside twenty-four hours a day, was established more than fifty years ago. Those were the days when hospitals were scarce and places of dread rather than places of hope. They were the days of hot stove-lid applications or of waiting to see "what it turns into" before calling the physician. Patients were more remote from their physicians because of muddy roads and no telephones. Typhoid, diphtheria and other infectious diseases were common. It was imperative to have a nurse on constant duty in the home. The majority of patients today can get along without continuous nursing care. This is constantly demonstrated in visiting nurse service and in ward care of patients. The average patient suffers no danger under intermittent or hourly nursing. Rather, his well-being is promoted, for he does not worry over the high costs and household inconvenience of one or two full time nurses in his home. A nurse coming in for three or four hours at a time, or dropping in two or three times a day, can furnish all the skilled nursing care that is needed for many patients. She can instruct some one in the household in caring for the other needs of her patient in the hours when she is not there, or perhaps no other care is needed. The broad extension of the intermittent or hourly nursing principle, designed primarily to bring adequate skilled service to the patient in modest circumstances, is essential if one is to reduce the cost of nursing and at the same time not lower its quality. This extension, however, depends on two major factors: the reeducation of the community, doctor and nurse in the use of nursing service; and the development of organized facilities for meeting all types of nursing needs. As in all purchasable things, it is the consumer who will ultimately determine whether or not he wants this form of nursing. But the consumer's taste is cultivated by judicious publicity, and this is precisely what is needed in developing hourly nursing.

HAMILTON, WALTON: AN ECONOMIST AUDITS HIS COSTS, Survey Graphic 16:380 (Jan.) 1930.

In the delicate task of fixing a just price the physician has little to guide him. If his charges are above those customary, the burden of proof is on him. If his exactions become notorious, he will drive patients away. If he departs too far and too often from the schedule fixed by the local medical association, where there is one, he may get into trouble with his brethren. The "market" hardly tells him what to charge, as it tells the cotton-grower and the coal operator; there is no regulatory commission, as there is for the charges of railways and public utilities; there is no principle, no criterion, no stand-

ard that will stand him in stead as a yardstick. The plain truth, too frequently overlooked even by the man of medicine, is that the physician's time does not easily lend itself to quantitative purchase. In reality there is no such thing as a unit of medical service. The common ills may possibly yield before the ritual of the technician; but every critical illness, acute or chronic, is a case unto itself. Cases seemingly alike differ in the demands which they impose in time, in energy, in skill, and in responsibility. At the very least a standard method of treatment must be nicely adapted to the changing circumstances of the patient's condition. Nor can the time of one physician be easily measured against that of another. A half hour with a great diagnostician holds more genuine medical service than an eternity of the time of a so-so medico. For that reason the rate of charge has little to do with the size of the bill. A high rate per hour or per visit may go with a small bill; low rates are not infrequently associated with large ones. After all, the payment is not for labor or time; it is for getting the job done so that it will stay done.

MARK, MARY LOUISE: A PROFESSOR PRICES BABIES: WHAT 540 NEW CITIZENS COST IN COLUMBUS, Survey Graphic 16:386 (Jan.) 1930.

Columbus parents paid for these 540 babies, the "run of the mine" of a city's natural increase, all the way from \$692 to nothing at all. In each of three population groups, at least one baby had parents able to pass this strait in their affairs without cost to themselves. The highest expenditures, however, varied considerably, being \$692 for the native whites, \$407 for the foreign and mixed whites, and only \$180 for the Negro group. The 540 babies cost on an average \$110. The babies of parents in distinctly comfortable circumstances (earnings of \$3,000 or more) cost \$270; those born to parents of intermediate status (earnings of \$1,200 to \$3,000) cost \$129; those born to the very poor (earnings under \$1,200) cost on an average only \$64; and those whose parents were dependent on the health or social agencies of the community during this pregnancy or within recent date cost their families the small average sum of \$27.

RAPPELLE, W. C.: COMPARATIVE EXPENDITURES FOR MEDICAL CARE, J. A. M. A. 94:1787 (May 31) 1930.

The financial aspects of medical care are receiving so much emphasis of late that there is a distinct tendency to lose sight of the relationship of this question to other national expenditures. The annual cost of nongovernmental medical services represents about 2.4 per cent of our national income. Governmental expenditures provided out of taxation for medical and

institutional care bring the grand total to about three billion dollars (3 per cent of the national income). Studies of the expenditures for medical care in different economic groups have given figures of approximately \$60 for the families of wage earners, \$62 for those of farmers and \$80 for those of office employees. Compared with this, the annual family expenditure for passenger automobiles is \$150, for tobacco products \$67, candy \$37, gasoline (noncommercial) \$37, theaters, movies and entertainment \$35, soft drinks, ice cream and gum \$34, jewelry and fur articles \$29, radios and musical instruments \$16, sporting goods, toys and games \$16, and perfumes, cosmetics and toilet soap \$15, or a total national nonmedical expenditure of \$436. These figures are presented only to indicate the relative expenditures for medical services and not to minimize the facts that illness and disability are very unevenly distributed through the population and that the largest problem before the medical profession is to secure an adequate distribution of modern medical services to the entire population at a reasonable cost.

NATIONAL HEALTH INSURANCE, CUTS AND CRITICISM, editorial, Brit. M. J., Jan. 14, 1933, supplement, pp. 1-14.

Since the National Health insurance Act of 1911 there have been seven alterations of the capitation fee. The first four were increases. The fifth was a reduction accepted by the insurance practitioners in view of the economic conditions of the time. The sixth arose out of a court of inquiry which awarded a higher sum than that offered by insurance practitioners on the advice of the association. The seventh alteration—the present temporary deduction of 10 per cent—came into force in October 1931. The correspondent referred to above lamented that “the B. M. A. is incapable of protecting our financial interest.” Perhaps he was ignorant of the four increases obtained through the efforts of the Association, which forced the government in 1912 to increase the capitation fee from 4s. to 7s. 3d. As a result of this action, insurance practitioners as a whole received, up till the end of 1931, *an extra* £60,000,000. In 1918, and again in 1919, the association obtained for certain sections of insurance practitioners bonuses which, from 1918 to the end of 1931, brought about a further increase of £1,500,000. When the association, after arbitration, secured in 1922 and 1923 a capitation fee of 11s., it put another £3,500,000 into the pockets of insurance practitioners. In 1924 the ministry’s offer was refused and a court of inquiry demanded; as a consequence the ministry’s figure was increased by 6d.: this meant another £3,000,000 to the association’s credit. In 1920 the association obtained an increase of the mileage grant from £34,000 to its present amount of £250,000 another £2,500,000 for insurance practitioners. By its continued efforts the association has, since the passing of the act of 1911 to the end of 1931, secured some £70,000,000 for insurance practitioners.

PROPER AND SUFFICIENT MEDICINES, editorial, Brit. M. J., March 1, 1930, p. 405.

A year ago the Minister of Health appointed an Advisory Committee on the Definition of Drugs for the Purposes of Medical Benefit. This committee has presented two reports on the matters referred to it, and these have now been circulated by the ministry to Insurance and Panel and Pharmaceutical Committees. In the first report the committee suggests a new regulation defining the procedure to be adopted when a medical practitioner has ordered, or is alleged to have ordered, on the official prescription form, any "substance or article" which is not a "drug or medicine." In the second report the committee classifies 165 substances and preparations which have been referred to it into those which are never drugs, those which are always drugs, and those which are sometimes drugs. Articles in the last two classes are subdivided into nonproprietary and proprietary. These last, again, may be of known composition or may be of a composition which is undisclosed. The committee considers that in the former case "an insurance practitioner might reasonably be called upon to justify the prescribing" of them, and in the case of the latter says "the prescribing of such substances and preparations is most undesirable; only the most exceptional circumstances could justify a practitioner in prescribing them." Of course, the classification of these substances by the Advisory Committee is not final. The decision as to allowance or disallowance rests primarily with insurance committees, and the decision in any particular case could be challenged in a court of law. Nevertheless, these reports will be of value to those committees, as well as to insurance practitioners and pharmacists. But if (as the committee now appears to lay down) "any question" is to be regarded as including the right of a patient to have given to him, or prescribed to him, the drug or preparation which he thinks he ought to have, irrespective of whether the practitioner thinks it appropriate or not, the medical profession could not for a moment countenance the right of an insured person to raise any such question. The word "refusing" seems to imply a "demanding" on the part of the patient. It would be a topsy-turvy kind of medical practice in which the patient named the drug and the doctor obediently prescribed it, or, greatly daring, declined to do so. The position with regard to the ordering of cod liver oil, extract of malt, and preparations of these substances is dealt with in the second report of the committee. It is by no means free from difficulty. This has been emphasized by a recent case which has attracted public notice. A partnership of doctors of the highest reputation, practicing in one of the poorest parts of London, has had a considerable sum deducted from the amount payable to it by the London Insurance Committee on the ground of "excessive prescribing," particularly with regard to cod liver oil and malt. The practitioners maintained that this was required owing to

the poor state of nutrition of a number of their patients. It is unquestionably desirable on medical grounds that any undernourished person should be supplied with further nourishment. The state has, however, established means by which, in approved cases, alimentary needs can be supplied; and even if communal action does not go far enough in this direction, there are plain reasons why such deficiencies should not in general be made good at the cost of a fund established for therapeutic purposes. Any other course might be held to justify the ordering of loaves of bread or pounds of butter or pints of milk for necessitous patients at the expense of the Drug Fund. Medical considerations alone should decide in each case whether cod liver oil and malt extract are to be regarded as foods or as drugs. The Advisory Committee on the Definition of Drugs, after weighing the arguments, reaches the cautious conclusion that these substances "are occasionally prescribed in circumstances which render it difficult to establish that their use was therapeutic rather than alimentary"; or, in other words, that malt and oil "may be, but are not always, drugs or medicines for the purposes of medical benefit."

FINKENRATH, KURT: SOCIAL INSURANCE IN SWITZERLAND, *Deutsche med. Wchnschr.* 56:1223 (July 18) 1930.

In Germany the most discussed phase of medicine is the increasing cost of social insurance. This cannot be explained on the basis of German statistics on social insurance because they do not cover the subject of the increased incidence of sickness among the members. In this connection, however, a report of the public social insurance society of the Basel canton for 1928 is highly significant because in it one can follow the frequency of sickness among the members over a period of fifteen years. In 1915 the number of patients was 41,708, or 128 per cent of the membership, whereas in 1928 it was 134,868, or 153 per cent. With the exception of a slight interruption caused by the influenza epidemic in 1918, the increase was continuous. The Swiss Social Insurance Society concluded that this increase in the frequency of sickness was only apparent and was caused by an increase in the number of patients who came for the treatment of trivial conditions; it stated that "the unnecessary demands for medical treatment that are being made on the society are assuming greater and greater dimensions." From 1921 to 1928 the number of consultations per member increased from 3.37 to 3.74, and the number of house calls from 1.18 to 1.26. Since 1924 the number of members in the Basel Social Insurance Society has increased only 13 per cent, whereas the number of consultations has increased 37 per cent. These statistics enable one to compare also the number of consultations held by general practitioners and by specialists. The number of consultations held by general practitioners showed

an increase of 26,000, whereas the number held by specialists showed an increase of 55,000. From 1923 to 1928 the proportion of patients treated by general practitioners dropped from 68 to 62 per cent, whereas during the same period the proportion of patients treated by specialists rose from 24 to 30 per cent. This increase in the frequency with which the members of a social insurance society consult specialists has been accompanied by an increase in the cost of social insurance.

GERMAN SICKNESS INSURANCE STATISTICS, *Aerztliche Mitteilungen*, 33:132, Feb. 13, 1932, p. 132, and *Deutsches Aertzteblatt*, June 23, 1934, p. 651.

Statistics of German National Krankenkassen Exclusive of Minors Since 1885

Year	Number of Insured with Dependents	Total Reg. Expenditures, RM	Payments to Physicians	Medical Percentage Costs per of Expenditures Paid to Physicians	
				RM	Physicians
1885	4,294,173	52,220,926	9,060,945	2.11	17.3
1886	4,570,087	57,833,328	10,335,524	2.26	17.8
1887	4,842,226	60,425,358	11,023,119	2.28	18.2
1888	5,398,478	67,729,060	12,523,435	2.32	18.4
1889	6,144,199	77,580,763	14,611,608	2.38	18.8
1890	6,579,539	81,816,550	16,788,438	2.55	18.4
1891	6,879,921	86,954,297	17,859,712	2.60	18.4
1892	6,955,049	102,502,615	19,068,892	2.74	18.6
1893	7,106,804	110,894,001	21,423,856	3.01	19.3
1894	7,282,609	108,306,555	22,209,891	3.05	20.5
1895	7,525,524	113,909,908	23,141,102	3.07	20.3
1896	7,944,820	119,228,063	24,813,242	3.12	20.8
1897	8,337,119	130,711,992	26,914,241	3.23	20.5
1898	8,770,057	139,444,690	29,107,863	3.32	20.8
1899	9,155,682	157,153,979	31,918,163	3.49	20.2
1900	9,520,763	171,584,173	34,331,368	3.60	20.0
1901	9,641,742	178,039,195	35,636,010	3.70	20.0
1902	9,858,066	183,328,868	37,499,311	3.80	20.4
1903	10,224,297	189,896,723	40,765,699	3.99	20.4
1904	10,710,720	234,084,806	47,914,471	4.47	20.4
1905	11,184,476	253,835,378	53,113,137	4.75	20.9
1906	11,689,388	264,236,033	57,239,080	4.90	21.0
1907	12,138,966	299,094,756	63,325,782	5.22	21.1
1908	12,324,034	325,054,492	67,692,047	5.49	20.8
1909	12,519,785	334,563,748	71,335,248	5.70	21.3
1910	13,069,375	350,545,175	76,440,495	5.85	21.8
1911	13,619,048	392,524,744	83,754,224	6.15	21.3
1912	13,217,705	395,036,896	85,693,295	6.48	21.6
1913	13,566,473	432,773,430	93,941,390	6.92	21.7
1914*	15,609,686	502,493,000	104,041,000	7.46	20.7
1924	17,287,841	864,674,000	205,729,000	11.90	22.8
1925	18,234,970	1,169,911,000	241,421,000	13.24	20.2
1926	18,402,147	1,229,720,000	257,988,000	14.02	21.0
1927	19,168,859	1,459,800,000	327,001,000	17.06	22.4
1928	19,879,908	1,738,013,000	306,293,000	18.42	21.1
1929	20,173,406	1,888,961,000	302,576,000	19.46	20.8
1930	19,597,459	1,691,048,000	375,085,000	19.14	22.2
1931	18,330,344	1,401,680,000	313,463,000	17.10	22.4
1932	16,439,074	247,618,000	15.06

* To 1914 includes dental care.

SICKNESS INSURANCE—DESCRIPTIVE

A. G. P.: THIS PANEL BUSINESS, London, John Bale, Sons & Danielsson, Ltd.

There has been a steady increase in the number of physicians in relation to population, and a corresponding decline, aggravated by general industrial conditions, in the income of physicians. "There are about 17,500 insurance practitioners, at least 10,000¹ noninsurance practitioners and several thousand specialists. There exists the very striking contrast that while 17,500 of the poorer practitioners are dealing with more than three quarters of the population, a combination of about 13,000¹ of the wealthier doctors and specialists are living in affluence—in comparison with the average insurance practitioner—on less than one quarter of the population, that quarter it must be remembered, who, because of their better environment and upbringing, should be the healthiest section of the people." There is excessive medication and hasty diagnosis. There is a continuous clamor for the extension of national health insurance, notwithstanding the statistical results of national health insurance which have been terribly disappointing. In spite of all the publicity of the benefits of insurance, the number of people who do not think it worth while to register with a panel doctor, a privilege for which they are forced to pay, has increased from 281,000 in 1927 to 620,000 in 1931. The physicians are compelled to yield to the demands of the patients for drugs and certification, in order to retain their panels at a size that will support them. In many cases there is a sharp discrimination in the accommodations offered and attention given between panel and private patients. In order to retain his patients, a physician is compelled (by custom and courtesy, not by law) to do a large amount of paper work in the form of certificates and other documents required by various institutions. There are only 17,593 out of 39,870 registered practitioners who have registered for the panel. While the number of patients on the average panel was 976, in 1931, there are many practices with the full limit of 2,500, which means that there is an increasingly large number with very few patients. The expenses of panel practice have been put at about \$1,100 a year, and the average gross income amounts to a little less than \$2,000 a year. Panel physicians do not show a great interest in keeping up to date or doing any graduate work. The insurance system has not abolished club and contract practice; on the contrary, these have extended into all classes of the population, and in some of these the physician accepts patients for six cents a week. This general situation leads to the conclusion that private practice is practically doomed, and the action of the British Medical Association in taking up various schemes for its

1. This number includes several thousand who are officially "retired" from active practice.

extension is explained on the ground that there is no other road that it is now possible to follow. "In 1930, of the 531,941 patients referred to the Regional Medical Officer, only 1,852 were cases sent up by the doctors. In 1931 the figures were 644,332 and 2,851 respectively. It would appear that either the doctors' doubtful cases are few and far between, or that for some reason they are reluctant to make use of the Regional Medical Officer for a second opinion." The practice of "farming out" panel practices, by which one physician hires one or more assistants to do the actual work, is widespread and has led to great abuses, but no effective action has been made to check it. The author is by no means opposed to insurance but offers a number of suggestions for improvements which he thinks might put the scheme on a sound basis:

1. "A maximum panel list of 2,500 on condition that the doctor undertakes to do no private work, or if he wishes to do private work his maximum should be 1,250.²
2. Alter the partnership rules to stop doctors drawing money without working for it.
3. A subcommittee of experts to decide questions of range of service and breaches of the regulations.
4. Ignorance of the rules not to be accepted as an excuse.
5. Greater fines, say a minimum of £50, for wrongful certification.
6. Refer every patient to the Regional Medical Officer.
7. A receipt to be given by the doctor for every sum accepted from a panel patient, such receipts to be examined by the authorities."

A CRITICAL ANALYSIS OF SICKNESS INSURANCE, AMERICAN MEDICAL ASSOCIATION BULLETIN 29:49 (April) 1934.

A series of tables gives the provisions of the present national sickness insurance systems, especially with regard to coverage, services, and relations with physicians. Sickness insurance arose out of an effort to relieve poverty and reduce political discontent. There have been continuous changes in nearly all systems indicating constant experimentation in the effort to find satisfactory forms of organization. The change from small voluntary societies to great state institutions depersonalized relations and caused the insured to seek to get as much as possible out of insurance. The insurance societies have continuously tried to control the medical service and to operate it according to industrial and commercial patterns. In this effort they have had the support of the International Labor Bureau, which is committed to a program for the extension of insurance. There has been a continuous extension of coverage and services in most of the

2. The figure is still above the average.

systems. While in the beginning the cash payments during disability was the principal feature, and the institutions were created primarily to administer cash relief, the medical side has constantly grown in importance until today it is the dominant feature in nearly all systems. The carriers of insurance in their efforts to control the physician seek to establish medical institutions under lay management. In the most successful systems—those of France, England and the Scandinavian countries—such institutions are either forbidden or have never become of importance. Because the benefits in social insurance are distributed to individuals instead of being furnished to the whole body of citizens as are police and fire protection, public hygiene, education, and the like, they lend themselves to manipulation by politicians for the purpose of securing votes.

There is great disagreement as to the quality of the medical service. In many systems it is claimed that it is much superior to what the mass of citizens who are now insured received previous to insurance. It is, however, generally admitted that there is a tendency toward superficial diagnosis, overmedication and excessive hospitalization. Where the societies have been able to establish their own institutions, these tend to over-emphasize laboratory and mechanical forms of treatment.

In nearly every insurance system the rate of morbidity tends constantly to increase. This is largely due to a desire to obtain the cash benefit for disability. In Germany when inflation destroyed the value of money the number of days of sickness, as measured by the inability to work, fell off nearly 50 per cent. However, in the case of dependents where no cash benefits are given there has been an almost equal increase in morbidity. This seems to be due to the desire of the insured to get something for his payments, and also, in the opinion of many psychologists, to the fact that free medical service tends to develop neuroses.

In many systems it is claimed that so much of the time of the physician is occupied with minor diseases that there is a neglect of any thorough diagnosis. In most systems of insurance there has been an extension of the efforts of the insurance carriers to determine what physicians will be employed and to reduce the payments for medical services. This has led to sharp conflicts in most of the European systems and especially in Germany. The removal of the control of the physicians from the societies in France, England and the Scandinavian countries has made this conflict less sharp. The carriers oppose free choice of physician and seek to control prescribing. In Sweden and France and a few other countries in which a portion of the charge is borne by the patient at the time the service is given, the difficulties concerning excessive medication have been reduced. Nevertheless it remains a general rule that a few years after the introduction of insurance there is almost invariably a steady increase in morbidity as measured by the services demanded.

The physicians in the beginning of sickness insurance were usually favorable and often donated their services. Later they grew to oppose many features and in the more recently established systems have been able to avoid some of the worst

features of the older systems. It may be taken as a general rule that those systems are most satisfactory to both patient and physician in which medical service is most nearly controlled by the medical profession.

In Germany it has been found that the insurance physicians are much less interested in graduate study. They are compelled to study the technic of their relations with the society rather than the subjects that would improve their ability to diagnose and treat disease.

Insurance seems to have had no definite effect in abolishing quackery. Under the German system it prevails to a greater extent than perhaps in any other country.

The International Association of Physicians has issued a statement based on a very extensive questionnaire and study of the attitude of physicians to insurance. This statement is given in full. The association expresses its approval of the principles of social insurance but demands free choice and control of all phases of medical service by the profession.

There is no proof that insurance in any country has reduced the cost of medical care in the sense that less money is spent after than before insurance. Expenses of administration and increases in the demand for medical services seem to have rather greatly increased these expenditures. There is now a decided movement in many insurance systems in which such provisions do not already exist to place a share of the immediate burden of medical costs on the patient at the time the service is given. There is also a rather extensive movement to change insurance into some form of saving plan by which at least a portion of the cost will be segregated and returned to the insured person if not used.

It is questionable whether the insurance principle can properly and successfully be applied to the cost of sickness. Sickness is to a large extent indefinable, is frequently desired by the insured individual and, therefore, is difficult to measure or control.

The actuarial statistics on which various systems have been established have usually been found to be inaccurate. Even if the morbidity rate could be determined, the costs of treatment constantly change and do not lend themselves to actuarial measurements. It is noteworthy that, although all sickness insurance systems owe their origin to lay forces, the features that are now most widely approved have in nearly every instance been forced on the original scheme by the efforts of the medical profession.

BERNER, JORGEN: REPORT ON THE NORWEGIAN SYSTEM TO THE INTERNATIONAL MEDICAL ASSOCIATION, Rev. internat. de méd. professionnelle et Sociale 6:59 (Nov.) 1929.

The insured in the official societies of Norwegian sickness insurance does not have the right to free medical service, thus forming an exception to the rule that prevails in the insurance systems of all the other countries except France. The insured

are required themselves to pay the doctor and the society returns to them a part of the expenses according to a fee schedule fixed by the government.

When this system was introduced in 1926 (up to this time medical care had been completely free and the insured and the physician received their payment from the society) it was with some apprehension that the arrangement was accepted by physicians. It was generally expected that the incomes of physicians would be considerably reduced. However, after the four years that we have worked under this system, we may say that this fear was not justified. The expenses of the societies have been reduced for medical care, it is true, but if one adds to the expenditures of the societies the sums that the insured themselves pay it is evident that the reduction was only the equivalent of the reduction made in the fee schedule by the medical association due to the general change in the price level. It might be said, therefore, that the majority of the members of the medical association do not object to the continuance of the system of repayment. On the other hand, this system has raised much objection among the insured, who already had the habit of not paying anything, and the societies also objected because it rendered their control of the insured, especially those incapacitated for work, more difficult.

For these reasons the government found it necessary in 1928 to appoint an official commission to work out a proposition with the object of securing an arrangement by which medical assistance would once more be given entirely free. This committee was also charged with a technical revision of the law. The commission was formed of representatives of the societies and of two physicians, of which Dr. Berner was one, owing to the demand of the Norwegian Medical Association. The commission presented its proposal this spring. The commission has not been able to agree on a common proposal and the members of the commission, with the exception of the two physicians, recommended the reintroduction of free medical assistance only after:

1. A system of payment like that existing in England was introduced. That is to say, a payment for the insured per capita.

2. If the German model was introduced, to be accompanied by a system of lump payment.

The physicians on the commission disapproved of both systems as irreconcilable with the profession of medicine, which is a liberal profession, and they charged that this would be disadvantageous not only for the physician but also for the insured.

The societies declared that since these systems were introduced in other countries they ought at least to be tried in Norway. In addition to the fundamental objections that were made to these systems, it was said that the conditions of work of the physicians in the different countries were so different that what might be suitable in one locality is not, therefore, proper to be forcibly adapted everywhere. (He then gives figures showing the much smaller population per area in Norway as compared with other countries.)

In 1929 several new clauses of the Norwegian Sickness Insurance Law became effective. Their object was economy and are without special interest to the physician.

Thus there has been a new recognition of the scale of daily cash payments for the sick. These, which were formerly the same for married or single, are fixed according to the income of the insured. The payments to the single insured are now reduced in comparison to those who are married. The Norwegian official societies for sickness insurance have never given drugs free to the insured, but bandages and minor accessories were supplied for surgical treatment. These services no longer exist. The money formerly paid to a family during maternity for assistance in the house has also been withdrawn. Otherwise there have been no changes in the regulations that have been put in force. It is necessary to add that there is a tendency in Norway to extend insurance and to create a voluntary insurance. The Norwegian Medical Association is inclined to approve this extension of insurance.

A further report of the Norwegian Medical Association in the *Revue internationale* for August 1931, pages 64-65, says:

"The society pays only a part of the medical cost (fees to the physician) according to a schedule of responsibility. In some localities the difference between this fee schedule and that of the physician is very small (as for example in the northern districts, where the fishermen are nearly all indigent). In other districts it is very important. In Oslo the difference is larger and the insured are covered in the neighborhood of 66 per cent of the costs of medical service.

The law has always permitted the societies and the physicians to make contributions under which the insured may receive entirely free medical service and the societies pay entirely and directly the medical fees. Since last autumn, negotiations have been under way with a view to the formation of such a contract, but up to the present time an agreement has not been reached.

BRITISH MEDICAL ASSOCIATION'S PROPOSAL FOR A GENERAL MEDICAL SERVICE FOR THE NATION, London, August, 1930.

The report is the culmination of work which the British Medical Association has been doing for the last thirty years in connection with the various developments in the provision of medical assistance by the state and local authorities. It is not a scheme which the association is pressing on the attention of the government. It is simply a record of proposals which the association is making as to the way in which the medical services of the nation should develop, submitted for the consideration of all who are interested in this matter. It is a contribution from the side of the medical profession to the discussion of a matter of great public interest, designed to influence public opinion in advance of the time when the developments mentioned in the report become practical politics.

The scheme is based on the following principles :

I. That a satisfactory system of medical service must be directed to the prevention of disease no less than to the relief of individual sufferers.

II. That the medical service of the community must be based on the provision for every individual of a general practitioner or family doctor.

III. That a consultant service and all necessary specialist and auxiliary forms of diagnosis and treatment should be available for the individual patient, normally through the agency of the family doctor.

IV. That the interposition of any third party between the doctor and the patient, so far as actual medical attendance is concerned, shall be as limited as possible.

V. That as regards the control of the purely professional side of the service, the guaranteeing of the quality of the service, and the discipline of the doctors taking part in it, as much responsibility as possible should be placed on the organized medical profession.

VI. That in any arrangements made for communal or subsidized or insurance medical service the organized medical profession should be freely consulted from the outset on all professional matters by those responsible for the financial and administrative control of that service.

VII. That medical benefits of the present national health insurance acts should be extended so as to include the dependents of all persons insured thereunder and entitled to medical benefit.

VIII. That every effort should be made to provide medical and nursing service facilities in institutions (home hospitals) where the family doctor may treat those of his own patients who need such provision and who can thus remain under his care.

It is proposed that there should be a general medical and dental service under the contributory insurance scheme. The services should be provided by the local authority, for the community generally, and as supplementary to the voluntary hospital system, and supplementary to, but apart from, the insurance scheme. They should provide special care for tuberculosis and other diseases and certain services for children of school age and a general health service.

The scheme should be administered by the Ministry of Health as the central authority, and the county or county borough council as local authorities with administrative medical officers, a central consultative medical committee, and the local medical committees.

FLEMING, GRANT: THE MEDICAL ASPECTS OF NATIONAL HEALTH INSURANCE, *Ann. Int. Med.* 8:220 (Aug.) 1934.

Vital statistics show that a large percentage of deaths may be classified as preventable. That they are not prevented is due to the fact that medical knowledge and medical practice are not

brought together. This gap is not closed because of the economic barrier. The sliding scale is no longer effective because every medical practitioner does not have an equal share of practice among all economic groups in order to even out his fees.

The problem may be stated as the provision of adequate medical care for all, with reasonable remuneration for those providing the medical care, by making it possible for all to contribute their share of the cost.

National health insurance is suggested as one means whereby this problem may be solved. The medical profession holds a strategic position in national health insurance because it has a monopoly of the knowledge of the main field of service which it is the aim of health insurance to provide.

The organized medical profession should control the professional side of medical services, but in matters of business arrangements for national health insurance the lay power should be supreme.

A fair criticism of national health insurance is that it has not been preventive either in outlook or in practice. There should be such a combination of public health and private practice as properly to cover the entire field.

The best type of medical care is built around the general practitioner. The first objective of national health insurance should be to make available the services of a general practitioner. National health insurance should require that specialists be designated and that they receive their cases through the general practitioner who seeks their assistance in problems of diagnosis or treatment.

Geographic location and other conditions limit the freedom of choice of physicians. National health insurance would make freedom of choice of physician much more of a reality, because every qualified medical practitioner should be eligible to practice and the economic barrier would be removed.

Whatever cash allowance is to be provided should be paid out of unemployment insurance and not out of health insurance.

The medical care of the indigent is the responsibility of the state, which should pay the insurance premiums of the indigent.

LEHMANN, HELMUT: *AERZTE UND KRANKENKASSEN*, Berlin, 1929.

The bulk of the work consists of the laws, regulations and decisions in relation to sickness insurance in Germany. The introduction by Lehmann sets forth the *kranken-kassen's* position. The first sickness insurance legislation was enacted in order to give economic help to industrial laborers who had been brought to poverty through sickness. Consequently, the cash payments were the foremost consideration. Only a few socially inclined physicians had any conception of the possibilities of medical care. It is characteristic of the time that the newly organized workers who were seeking to win over the insurance societies for political purposes had as a slogan "Free choice of physician." When the victory was won, however, there was a general

enforcement of district physicians. To be sure, the representatives of the labor organizations did not mean quite the same as the leaders of medical organizations by free choice of physician. The former were seeking to abolish the abuses of the district physician and wished to compel all physicians to take insurance service. The best class of physicians had not taken insurance positions. By 1892 the societies were beginning to control the admission to insurance practice and to introduce the system of restricted free choice of physician. The medical organization based its demand for free choice on the necessity of mutual confidence and it wished to assume the responsibility for its members. The carriers rejected these demands as an attempt on the self government of the *krankenkassen*. The medical organization also opposed the lump sum payments and asked for payments according to the medical act. This medical organization had been formed in 1900 and from 1901 to 1913 was in continuous and bitter conflict with extensive strikes of physicians. In 1913 the government intervened and secured the so-called Berlin agreement. This gave the societies the right to limit the number of physicians and did not definitely recognize the right of free choice. An arbitration body was also established; nevertheless there was another general strike in May 1920. The inflation period practically abolished the Berlin agreement. By the new agreement, which was formed in October 1923, the physicians were compelled to recognize formally economic conditions and the capacity of the societies to pay for medical services and to restrict their services accordingly. This led to another general strike in November 1923, which lasted until February and, in Berlin, until June 1924. In 1924, regulations for new forms of contracts were established.

DIE ARZTFRAGE IN DER SOZIALVERSICHERUNG DER EINZELNEN STAATEN, Published by Hubert Korkisch, Prague, 1926.

This is a symposium containing articles from public officials, physicians and society representatives concerning the workings of insurance in Germany, Austria, France (before the present law), Great Britain, Switzerland and Czechoslovakia.

O. Heineman, a member of the union for the protection of the interests of the German industrial *krankenkassen* in the Ruhr district, writes on the organization of medical service in German sickness insurance with special reference to the industrial *krankenkassen*. He advocates the extension of clinics in insurance practice but recognizes their mechanical character as rendering them unsuitable to certain situations. The *krankenkasse* is to be considered only as a medium of securing medical service and does not mix in the relations between physician and patient, which depend on the confidence of the patient in the practicing art.

Helmuth Lehmann, the head of the Central Organization of the German Krankenkassen, discusses the society and physician question in Germany. He considers the physicians as the most important cooperators of the krankenkassen, not only because their services are the most valuable but because they hold the key to the treasury through their power to issue blank checks for cash relief. The constant increase in physicians has caused the number of patients per physician to decline from an average of 1,200 in 1890 to 400 in 1924, and the competition of physicians has caused the number of sicknesses among the insured to increase from an average of 32.6 per hundred insured in 1888 to 42.9 per cent in 1924. The number of days of incapacity for labor has increased in the same period from 16.8 to 25, the sickness costs from 10.50 marks to 44.70 marks, and the cost of drugs and medical supplies from 2.70 marks to 5.30 marks. The constant demand for increased payment on the part of the physician has caused the per capita expenses for payments to the physician to increase from 3.60 marks in 1900 to 11.87 marks in 1924. He urges the substitution of clinics with salaried physicians and describes the extensive equipment installed by the Berlin krankenkassen. The krankenkassen and the government have sought to extend the field of medical services to social hygiene and have established extensive institutions for the treatment of tuberculosis and venereal diseases. It is plain that the number of physicians who will be entirely in the service of the carriers of social insurance will increase rapidly in future years. The development from individualistic to social medicine will gain an enormous advantage when more of these energies are turned to prevention and general social hygiene.

Dr. Rudolph Lennhoff and Dr. Kurt Finkenrath discuss the relation between the krankenkassen and physicians in Germany, prior to the Nazi régime. The principal unions of the German krankenkassen are very close to the Social Democrats. The union for the protection of the German industrial krankenkassen and miners' societies is closely connected with the heavy industry and the German Volkspartei. Another union of the German krankenkassen has its leaders in the center parties and in the German National Volkspartei. The general union of the German rural krankenkassen joins its interest with that of the agrarians and its political representatives are in the German National Volkspartei. In the voluntary period that preceded compulsory insurance, the physician either donated his services or received little more than nominal pay. The struggle between the krankenkassen and the physician in their mutual organization is described. With the constant increase of expenses for medical services came a continuous demand for a reduction in the payment to physicians. The inflation period rendered even what money was paid almost valueless so that at the end of 1923 an official statement of the Bavarian statistical department said: "The sacrifice of physicians has made it possible to carry social insurance over this period." No satisfactory adjustment

of the relations between the *krankenkassen* and the physician has yet been established in spite of the manifold regulations and institutions created for that purpose.

Supervising Director Schellhammer, on the free choice of physicians in the organization of medical service and social insurance, describes the conflict under the free choice of physicians which he considers is essential to any satisfactory solution of these relations.

W. Spielhagen, of the central government service, on sickness insurance in Germany, describes in detail the forms of organization and institutions that have been set up in all the various phases of insurance, and the struggle between the physicians, dentists and pharmacists on the one side and the *krankenkassen* and the government on the other.

Karl Unger, a member of the imperial health service, on medical service in the rural districts, considers the peculiar situations that exist in the rural districts. The competition between physicians is much sharper in small towns and country districts. When an attempt was made to pay according to the medical act, the number of services multiplied three and four fold between 1914 and 1924. An effort was then made to check this by requiring all patients who were able to walk to visit the physician's office. The result was that the number of office calls multiplied without any great diminution in the home calls. Various schemes were tried to check these excesses as well as the evils of excessive prescribing, but no success has been attained. The introduction of an extensive nursing system by registered nurses did not greatly relieve the situation and added to the cost. The net expenditures to physicians increased from 1914 to 1924, 97.2 per cent, for dentists, 168.1 per cent, for medicine, 57.4 per cent, for hospitalization, 73.6 per cent, with a very small increase in the number of members.

Dr. Alfred Korschinek, general director of the Austrian insurance office for government officials in Vienna, on the organized free choice of physicians in Austria, describes the origin and growth of the Austrian insurance system and the forms of bargaining and other arrangements that have been used in determining relations with physicians. Demand for medical services has steadily increased and the conflicts with the societies have been almost continuous. Specialization has grown and increased problems. The great excess of physicians to population especially since the war has accentuated all problems. The burden on the resources of the carriers has caused them to resist all attempts to increase the payments to physicians. If the leaders of the physicians and of the carriers and the government will cooperate, the system of free choice of physician at least in the insurance for civil service employees seems assured.

Dr. Rudolph Mertha, central administrator for social relations in Vienna, on the organization of medicine in Austrian social insurance, describes the legislation on which insurance is based,

the formation of the medical and krankenkasse organizations and the relations that exist between them.

Dr. Josef Stritzko deals especially with physicians in Austria and social insurance. The conclusion drawn from an international investigation was that insurance legislation in all countries is considered hostile to the physician and nowhere has it recognized the proper interests of the physician and has everywhere dominated the physician. The carriers have sought to convince their members that the physicians were inspired only by their own interests and have thereby aroused antagonism to medical measures in the interest of the health of the insured. Better conditions have existed since the war, but economic conditions in Austria have been such that the payments to the physicians have scarcely sufficed for existence. The charge that many positions in the insurance medical service are gained through politics rather than through medical qualifications is made.

The discussions on French and British insurance bring practically nothing that is new and up to date.

Dr. O. Leuch of the Central Organization of Swiss physicians, on physicians and the krankenkassen, says that the central conflict in insurance in Switzerland concerning the medical service is due to the fact that it destroys the natural relation between patient and physician. We are faced with the question Can sickness insurance bring the same advantages which a private patient receives? That is, can it give the same satisfaction to his demand for medical services that are received by private patients? The experience of the last decade teaches us that this question must be answered with a no. Here a constant source of conflict is the increase of medical costs. The development of modern medical science inevitably makes it more expensive. The fixed character of insurance makes it almost impossible to allow for this increase. Along with this comes the steady increase of demand for medical services which in part is due to insurance itself. Neither do we wholly deny that physicians as well as patients in some instances seek to exploit insurance resources. Medical organizations have sought to check such evils but so far with little result. The physicians have demanded that insurance be confined to the economically weak classes of society. The tendency has been to constantly take in higher paid classes.

Charles H. Weber, director of student insurance in Geneva, discusses the organization of Swiss insurance and the subventions received from cantons and cities. A combination of the smaller societies into larger ones is essential. There is wide complaint of misuse or excessive use of medical service. Various systems of payment have been tried to check these. The excess of physicians has accentuated these abuses. The whole insurance system is dominated by the question of the relation with physicians. Eighty-five years ago, when the first mutual societies were formed, physicians gave their care for nothing or for nominal charges. The great compulsory or semicomplulsory

institutions of today still expect sacrifices of similar character from the physician. Nevertheless we trust in the future. The insurance system has driven such deep roots into all sections of the Swiss people that it will overcome all difficulties, however great they may appear.

Karl Helbich discusses the relation of physicians to social insurance in Czechoslovakia. As soon as any one speaks of the physician and social insurance, a picture of two fighters arises—the physician and the *krankenkassen*. When insurance was first introduced in 1888, the physicians were by no means hostile and gave their services at very low rates. Physicians were among the first to call for an extension of compulsory insurance to the home and agricultural workers. Today one cannot rightly speak of antagonism of physicians to insurance but of a conflict over the different ideas of the purposes of insurance. While the physicians see an opportunity for medical service, the *krankenkassen* look only on the financial transactions. According to the opinion of the physicians, the purposes of sickness insurance should be ranged as follows:

1. To restore the capacity to labor.
2. To protect the capacity to labor.
3. To insure the maintenance of a standard of life.

These objectives have been practically reversed by the insurance societies.

Dr. Franz Koreis, secretary of a union of German *krankenkassen* in Bohemia, on physicians and medical service in Czechoslovakian sickness insurance, sketches a history of the introduction of insurance in Czechoslovakia. He holds that the strong organization of the physicians has gradually forced the *krankenkassen* into a position of defense where they must fight continuously to maintain their equality of power. The societies are especially opposed to demands for the introduction of free choice of physicians. Opposition to this is based not so much on the amount of payments as on the fact that under free choice of physicians there is an immediate excessive rise in the cash payments and in the costs of medical supplies. There are two classes of physicians engaged in insurance. One placed itself at the service of the *krankenkassen* and the other seeks employment with the *krankenkassen*. Free choice of physician can never come because there is always a section of the insured who do not understand the purpose of insurance and seek only to get all they can out of it.

INTERNATIONAL LABOR OFFICE: COMPULSORY SICKNESS INSURANCE, Geneva, 1927, Series M, No. 6.

This is a comparative analysis of national laws and statistics up to 1927. Historically, sickness insurance traces back to the guilds and to workmen's organizations. Restoration rather

than compensation is, however, the principal function of insurance. In its origin, insurance aimed at providing the sick with benefits in cash to replace the wages that they were unable to earn. Little by little this idea has yielded to a wider and more genuinely social conception, which makes the restoration of the patient the first consideration. Benefits in kind intended to restore the health of the patient begin to overtake cash benefits.

At the present time the majority of compulsory insurance laws apply solely or mainly to the social class of wage earners. The definitions of these classes and the extension of coverage is treated. The special conditions in the various national systems relating to coverage is set forth in detail and also in tabular form.

In regard to benefits: Two alternative policies may be followed in determining the nature of sickness insurance benefits. The first consists in granting the insured person a benefit in cash so that he may himself obtain the goods and services he requires, while according to the other the insurance institution is entrusted with the function of organizing the provision of whatever is needed by the insured.

In the present state of the development of social insurance neither of these policies is followed exclusively, but it may be affirmed that benefits in kind are becoming more important than benefits in cash.

For the purpose of insurance legislation, sickness is any abnormal mental or physical condition that necessitates treatment or the suspension of work, or both. A pathologic phenomenon is not in itself sufficient to constitute sickness as defined by insurance. It must also make the person unable to work or must call for treatment.

The conditions under which these various benefits are given differ in various states and the provisions in the principal systems are explained, together with statistics on the number of days of sickness and expenditures on sickness benefits in many of the systems. The methods of regulating the relations with the medical profession and providing medical service and treatments are described for the various nations.

The methods of remuneration of medical practitioners either by fixed salary, fee per insured person, fee per case of sickness or according to attendance are described.

While there have been some steps taken in the direction of prevention, measures for this purpose have not yet been included among the aims of all insurance laws and even when so included are not always widely applied.

In Europe during the period 1919-1923, the cost of sickness insurance approximated about 4 per cent of the average wage. The resources for this were obtained in part from contributions by the employees and the employers and from taxation. The various schemes for raising these resources are described and tabulated for all the present systems. A number of morbidity tables for all ages are given, with methods of calculating the actuarial risks. The various systems of applying these rules

in the various schemes and the methods of financing used are described. There is an international tabular summary of financial resources and their management.

The methods of organizing the institutions by the carriers of insurance vary widely in the different schemes, which are described in considerable detail.

There is no country where the management of compulsory sickness insurance is entrusted to private insurance companies. The object of such companies is to make a profit, and it would seem that they can carry on their work only at the expense of the insured. The idea of profits cannot be reconciled with the care for public health, and in most cases the insured will be unable to count on benefits in excess of the statutory minimum.

A justification of the management of the insurance institutions by the insured lies in the view that the contributions both of workers and of employers are only a form of wages, over which the workers should have the right of disposal,

These institutions are federated and controlled in different ways, which are shown not only in detailed description by nations but by a tabular summary. The administration of insurance laws in the ordinary course of events gives rise to fairly numerous disputes. These may arise concerning the scope, the contributions, administration, or in relation to the medical profession. The institutions that have been set up to settle these disputes are described, together with the list of the commonest offenses and the penalties therefor. An appendix gives a list of the principal official publications in each country dealing with insurance.

International Tabular Summary: Financial Resources and Their Treatment—Great Britain

Year	Amount of Contributions		Public Subsidies		Interest		Total Revenue, Including Miscellaneous Receipts		Contributions as Percentage of Total Revenue
	Total*	Average per Insured†	Total*	Average per Insured†	Total*	Average per Insured†	Total*	Average per Insured†	
1914	16,797	1.23	5,787	0.42	618	0.05	23,152	1.70	72.6
1915	18,284	1.80	6,457	0.45	899	0.06	25,640	1.82	71.3
1916	17,784	1.20	5,159	0.85	1,199	0.08	24,142	1.63	73.7
1917	18,166	1.18	5,764	0.37	1,628	0.11	25,569	1.67	71.1
1918	18,245	1.15	7,455	0.47	2,265	0.14	27,965	1.76	65.2
1919	18,205	1.18	8,685	0.56	2,721	0.18	29,560	1.92	61.6
1920	22,688	1.49	10,206	0.67	3,271	0.21	36,166	2.37	62.7
1921	25,190	1.67	11,759	0.78	3,695	0.25	40,644	2.70	62.0
1922	25,019	1.66	8,420	0.56	4,125	0.27	37,915	2.51	66.0
1923	26,204	1.73	6,947	0.46	4,751	0.31	38,397	2.54	68.2
1924	27,377	1.78	7,045	0.46	5,281	0.34	40,688	2.64	67.3
1925	27,719	1.78	8,073	0.51	5,633	0.36	42,416	2.72	65.0

* 1,000's of £.

† £.

INTERNATIONAL LABOUR OFFICE: VOLUNTARY SICKNESS
INSURANCE, Geneva, 1927, Series M, No. 7.

Voluntary sickness insurance traces back to guild organizations, and its development has been greatly affected by changes in social and economic conditions as well as by political theories and directly by legislation.

In some nations the voluntary organizations have been able to include a majority of the workers, but in most nations the proportion is much smaller.

Nevertheless, in spite of the force of the voluntary movement, freely created by the members, it cannot be considered as offering a fully satisfactory solution to the problem of workers' insecurity. Its effectiveness appears to be limited by three obstacles: small and unstable membership, insufficient revenue and benefits, dispersal of effort.

The scope of voluntary insurance remains too narrow: a large section of the wage-earners and the poorer population generally have failed to join provident institutions. This failure is especially marked in the case of persons whose earnings are low and who, by reason of their precarious livelihood, are more subject to disease, and whose need of insurance against the risk is therefore more pressing. Moreover, membership of mutual benefit societies is not constant but diminishes appreciably whenever an economic crisis occurs that causes unemployment and reduces wages.

In spite of the financial aid of the state, the resources of voluntary insurance funds are generally very limited. A general meeting does not willingly consent to the raising of the contributions. The inevitable result is that benefits are inadequate and the insured have to bear the greater part of the income loss and medical expenses.

Lastly, the geographic distribution of voluntary insurance institutions in any country is far from systematic: there are too many in the towns and too few in the rural districts. By reason of their number in certain areas they interfere with one another: if one grows it is at the expense of another, the stability of which is diminished, and the dispersal of effort hinders the organization of a good medical service and the creation of the necessary curative establishments.

The sole effective remedy seems to be to render insurance compulsory. Such was the view expressed by an imposing majority of the delegates to the tenth International Labour Conference (May-June 1927), which based the first international regulation of sickness insurance on the compulsory principle.

A survey of the history, legal status, types of funds, resources, benefits and statistics of operation is given for the following nations: Argentina, Australia, Belgium, Canada, Denmark, Finland, France, Great Britain, Northern Ireland, Irish Free State, India, Italy, Netherlands, New Zealand, Palestine, Spain, Sweden, Switzerland, Union of South Africa, Uruguay.

The evolution of sickness insurance in these various countries shows certain common developments. There is a constantly

increasing average size of the funds, with an increase in governmental subsidies accompanied by closer governmental supervision and a growing emphasis on medical service as compared with cash benefits. The latter has caused a steady and quite rapid increase in the sums expended for medical care in practically every system.

INTERNATIONAL LABOUR OFFICE: GENERAL PROBLEMS OF SOCIAL INSURANCE, Geneva, 1925, Series M, No. 1.

The whole field of social insurance is covered in this book with sickness insurance considered only as one of its forms with a tabular presentation of the situation in regard to the various forms of insurance in nearly all countries. Three solutions to the problem of classes of persons to be covered are found in the various insurance systems:

1. Insurance of economically weak persons.
2. Insurance of all economically dependent persons supplemented by optional insurance for independent workers, earning small incomes.
3. Insurance of specified groups of economically dependent workers, supplemented by compulsory or voluntary insurance or independent workers earning small incomes.

Portugal is the only country that has introduced a system of sickness insurance which is compulsory for "every individual without distinction of sex, following any vocation within the domain of human activity and recognized as worthy and honorable by custom and sanctioned by law."

The economic risk is in the ultimate analysis the risk of incapacity for work, and in order to determine the amount of the benefit it is of little importance whether the risk is of economic origin (unemployment), of physiologic origin (e. g., sickness) or of industrial origin (industrial accident).

In figuring benefits, four different standards are used: (1) equivalent to the economic loss, (2) equal to a part of the economic consequences of the risk, (3) to provide insured persons and their families with a minimum of existence, and (4) varying in proportion to the severity of the economic consequences of the risk and the amount of the payments made by the insured person or others.

It is recognized that the first method, which would require a system of benefits equal to the economic loss, is a purely theoretical one and is considered impossible of realization because of its enormous cost and because its application would inevitably lead to serious abuses, such as simulation of sickness and invalidity and voluntary unemployment.

The cost of social insurance in relation to employers and the state is discussed. In regard to the incidence of the cost of social insurance there are two theories concerning employers'

and employees' contributions. According to the first theory they will finally be incorporated in the prices of commodities, like other costs of production, and will be paid by the consumers. According to the second theory they will be incorporated in the price of labor and thus will finally be paid out of wages.

The methods of distributing the costs of insurance in national legislation in various countries is described, as are also the financial system utilized.

There is a discussion of the difference between social insurance and individual insurance and public relief. It is held that compulsory insurance is a necessity from the actuarial and financial point of view in many systems of social insurance.

Various forms of insurance institutions that have been set up are described and their defects and advantages considered. There is a general recognition that the administration of all forms of social insurance should be unified, but up to the present time only a few nations have proceeded very far in this direction.

MCCLEARY, G. F.: NATIONAL HEALTH INSURANCE, London, H. K. Lewis & Co., Ltd., 1932.

The author was formerly principal medical officer of the National Health Insurance Commission of England and a deputy senior medical officer in the Ministry of Health. The history of voluntary health insurance is traced from the Roman "Collegia" through the guilds of the Middle Ages and the friendly societies. The history of compulsory health insurance is given in the various countries up to the present time, and outlines of the features of the principal types are given. Health insurance in England was preceded by a wide system of contract practice of various forms. When the present scheme was proposed, the British Medical Association insisted on six cardinal points:

1. An income limit of £2 a week for those entitled to medical benefit.
2. Free choice of doctor by patient, subject to consent of doctor to act.
3. Medical and maternity benefits to be administered by local Health Committees and not by Friendly Societies.
4. The method of remuneration of medical practitioners adopted by each local Health Committee to be according to the preference of the majority of the medical profession of the district of that committee.
5. Medical remuneration to be what the profession considers adequate, having due regard to the duties performed and other conditions of service.
6. Adequate medical representation among the Insurance Commissioners, in the Central Advisory Committee, and in the local Health Committees, and statutory recognition of a local Medical Committee representative of the profession in the district of each Health Committee.

The "panel system" as created by these points did not owe its origin to the government. There is nothing about it in the bill as originally introduced. It was pressed on the government

by the British Medical Association as the method of providing insurance medical services which was most in harmony with the ideals of the medical profession. Each physician is restricted to 2,500 patients, which may be increased if he employs an assistant. Before the introduction of National Health Insurance, members of the friendly societies watched each other so closely that in a well managed system it was not easy to draw sick pay if not entitled to it. "But the national scheme brought into insurance for the first time millions of persons to whom the notion of providing by mutual assistance against sickness was unfamiliar. Many of these persons joined societies in which it was impracticable to secure the close supervision of sick members that was undertaken by the local lodges of the old friendly societies. Although sickness visitors were generally employed, it soon became evident that further steps had to be taken to protect the benefit funds, and shortly after the inception of the scheme it was decided to introduce an improved system of medical certification and to appoint a staff of medical referees." This required the creation of the Regional Medical Staff and the adoption of many additional checks on excessive sickness claims.

The efficiency of the medical service is maintained by a system of supervision, but "it may be said that the most effective influence that keeps him [the physician] up to the 'mark' is his own professional conscience." He is also under the supervision, in every administrative area, of a representative committee of insurance doctors. Another influence is the presence of the Regional Medical Staff, a body of medical officers well versed in the difficulties of medical practice. There is also a disciplinary procedure for handling complaints against practitioners made by insured persons or approved societies. An appeal can be made to a "tribunal consisting of one or more officers of the Ministry and also, if the complaint is of negligence in the treatment of a patient, a member, selected by the Minister, of a panel of insurance practitioners nominated by a central medical committee which is regarded by the Minister as representative of the general body of insurance practitioners—the Insurance Acts Committee of the British Medical Association." The tendency of insurance to increase "the morbidity" by encouraging the desire to get something back is discussed. To meet this, "in some countries the rates of sick benefits paid have been reduced." Another expedient is to require the insured person to make a direct payment toward the cost of treatment, and it would seem that the number of schemes in which this has been adopted tends to increase. The Insurance Act would not reduce the work of the Boards of Guardians in caring for the indigent. "In their separate Infirmaries the Guardians had 37,500 beds in addition to the 84,000 beds available for the sick in the work-houses. From data obtained in an inquiry made in 1927 into the institutional treatment of the sick in London, it was esti-

mated that for every ten patients treated in voluntary hospitals about eighteen were treated in Poor Law Infirmaries."¹

In the year 1930 the total sum paid in contributions in England and Wales by the insured persons and their employers was £23,392,900. Interest on accumulated funds amounted to £5,466,500, and the state contribution to £6,605,900. A sum of £29,640,700 was expended in benefits, and a further sum of £5,069,500 in the administration of the scheme. Of the latter sum, £4,109,900 was expended by the Approved Societies and Insurance Committees, and £959,600 in the central administration of the scheme by the Ministry of Health.² It will be seen that the administrative expenses formed 14.6 per cent of the total cost of the scheme and that 19 per cent of the cost was borne by the state.

METROPOLITAN LIFE INSURANCE COMPANY: HEALTH INSURANCE, A SUMMARY OF SOME EXISTING GOVERNMENTAL PLANS PROVIDING PROTECTION IN EVENT OF SICKNESS OR INVALIDITY, Monograph Three, June 1931.

The main features of the insurance systems of Germany, Great Britain and Denmark are briefly sketched. An international comparison classifies the various systems according to compulsory and voluntary and also as to certain types of voluntary systems. Ten compulsory plans and five voluntary plans are then selected for treatment in chart form giving the principal features of each scheme.

Financial Features of British Health Insurance

Year	Total Income	Per Cent the Total	
		Total Expenditure	Total Income
1916.....	\$117,500,000	\$ 75,800,000	64
1917.....	124,400,000	73,300,000	59
1918.....	136,100,000	82,700,000	61
1919.....	143,900,000	94,700,000	66
1920.....	176,000,000	127,400,000	72
1921.....	197,800,000	145,300,000	73
1922.....	182,800,000	144,600,000	79
1923.....	184,600,000	142,900,000	77
1924.....	193,400,000	150,500,000	78
1925.....	201,700,000	157,800,000	78
1926.....	182,100,000	180,300,000	99
1927.....	192,400,000	199,000,000	103
1928.....	188,500,000	182,900,000	97
1929.....	191,300,000	194,100,000	101

Reproduced from page 17 of the monograph.

1. Annual Report of the Chief Medical Officer of the Ministry of Health for the year 1928.

2. Twelfth Annual Report of the Ministry of Health (Cmd. 3937).

RINUY: DIAGNOSTIC CENTERS, *Presse méd.* 40:953 (June 15) 1932.

"The medical profession at first opposed insurance but accepted it with definite conditions written into the law, the most important one of which was direct personal relations between physician and patient.

"The societies are now attempting to evade the law by the establishment of diagnostic clinics. It is claimed that these are to be only assistants to the individual practitioners, but they are being established first in great cities where there is no lack of laboratory facilities, specialist service, etc., which these clinics are to supply.

"The societies cannot resist the temptation to build imposing structures across which they can inscribe in large letters, 'Diagnostic centers for the detection (dépistage) of disease.'

"The societies have already succeeded in getting the officials to give a partial endorsement to the establishment of such clinics, which it is claimed are to be under the direction of the physicians and are not to give any treatment. But the representatives of the societies are already preparing to give treatments and are arguing for this on the ground of economy.

"The societies have never accepted the law as it is now operating. They wish to be free to hire physicians who will obey their orders. They wish an anonymous medicine, given in series and cheaply. They wish their own hospitals, dispensaries and diagnostic centers."

REPORT OF THE ROYAL COMMISSION ON NATIONAL HEALTH INSURANCE, London, 1926.

This report was based on an examination of 195 witnesses and 143 statements, most of which were submitted by these witnesses. The total evidence fills four large volumes, each of which has an appendix printed separately containing the documents. The Majority Report gives a brief history of the scheme and the details of its essential features. "We have received very little evidence directed against the scheme as a whole, nor have we any reason to think that there now exists any considerable body of opinion adverse to the principle of National Health Insurance." Both the unemployment and the sickness insurance schemes are designed to alleviate the distress arising from the cessation of income due to causes beyond the worker's control and the question whether these causes are to be sought in ill health or in the failure of employment has no bearing on the needs of dependants.

The British Medical Association listed eight ways in which it considered that medical service had been beneficial and added that it is possible that some of them may not be wholly due

to the establishment of the National Health Insurance Scheme but that they have certainly been hastened and intensified by that system.

The various forms of additional benefits and the extent to which they are given is explained. The Society of Medical Officers of Health stated in regard to preservation of health: "It has become evident that the present system of National Health Insurance suffers great limitations in its possibility for promoting health and that profound changes are required if the improvement in the health of the people is to continue to be aided and not impeded by it.

"We are of opinion that the difficulties of a composite support to a completed medical service from insurance funds as well as from grants and rates would be so considerable alike in their financial, administrative and social aspects that some more practical solution must be sought. In particular we feel sure that the wider the scope of these services, the more difficult will it be to retain the insurance principle. The ultimate solution will lie, we think, in the direction of divorcing the medical service entirely from the insurance system and recognizing it along with all the other public health activities as a service to be supported from the general public funds."

The total burden of social services is estimated at about £308,000,000, roughly \$1,500,000,000, annually, and there was much complaint from employers as to the burden on industry.

There has been a continuous increase in medical costs. On the official evidence before us, the sum which it will be necessary to provide to cover the whole cost of the present medical benefit after 1926 will be 12s. 6d. per insured per annum.

While there was a large amount of evidence introduced criticizing the Approved Societies system, much of which the Majority Report considered as justified, the Majority Report did not consider it advisable to abolish the Approved Societies. It was recommended that a specialist service be made available to all insured persons as an integral part of the medical benefits under the insurance system but that for the present the existing arrangements for Maternity Benefit should in their general outline remain unchanged.

Because the dental condition of the industrial class is so deplorable, some form of dental treatment is required by from 60 to 80 per cent of the insured persons. The Majority Report felt that financial conditions made it impossible to recommend the inclusion of dental services as a regular benefit. For the same reason the question of extension to dependents should be left over to be considered in connection with any wider proposal for reorganizing the health services of the community.

Concerning the establishment of medical institutions to take the place of individual medical care, the Majority Report quoted the opinion of the British Medical Association that the treatment given at a number of these institutions is as a rule

inferior in quality to that provided under the normal panel arrangement and that administration and control by lay committees has proved in many cases to be ineffective. The majority, therefore, recommended that the act should be so amended as to debar anybody from sanctioning such institutions.

A reservation by two members concluded that there are grounds for believing that expenditure on health, unless primarily directed to the removal of the causes of ill health, may tend to further increase such expenditure. They cite the evidence of the British Medical Association that the alleviation or cure of morbid conditions when once they have arisen is, relatively to other matters, a minor part in the campaign for public health.

The present Minority Report differs from the Majority Report primarily in its demand that the Approved Societies be abolished and the administration be turned over to local authorities and also in recommending an extension of the services to include dental and maternity services and a general increase of the benefits.

SIMONS, A. M., and SINAI, NATHAN: *THE WAY OF HEALTH INSURANCE*, University of Chicago Press, 1932.

The controversial and consequently prejudiced character of much of the writings on health insurance makes it difficult to arrive at unprejudiced conclusions. Social insurance is a product of industrialism due to social, economic, scientific and political developments characteristic of the last half century. Insurance sets up very extensive and powerful institutions that act as carriers of insurance and also brings changes of considerable importance in the state and even more in the medical profession. Every system of health or sickness insurance is established primarily for the relief of poverty and not for the prevention of disease. The attempt to use it as a method of supplying medical service leads to conflicts and difficulties.

With the passage of time, insurance systems follow a familiar line of evolution. They all tend to change from voluntary to compulsory. This evolution has been hastened by the action of the International Labor Organization, which has adopted a convention pledging the affiliated states to introduce compulsory insurance of a quite definite pattern. This pledged the International Labor Office to campaign for this form of insurance. The function of the state tends to become increasingly important in administration.

The medical profession, at first indifferent, has felt that insurance profoundly transformed almost every feature of professional work. The German insurance system has been characterized by continuous conflict between the funds and the medical profession. As the system has expanded, it tended to monopolize medical practice. There has been a constant

increase in expenditures as a whole and also per member which has led to financial difficulties. The struggle between the medical profession and the funds centers around three issues: the amount and method of payment, lay control, and certification of incapacity for work.

The British insurance system was the first to be called health insurance and to include special sections designed to further prevention of illness. These sections have had almost no effect. The system was introduced following the report of the Poor Law Commission of 1909. Although that commission not only did not recommend health insurance but scarcely considered it, its introduction was largely a political move. The medical profession was not consulted before the law was proposed and consequently was forced to conduct a very expensive fight to secure measures protecting the interests of physicians and insuring the quality of the medical service. It was due to the action of the British Medical Association that the panel system was introduced. This admits any registered physician to insurance practice. It is only necessary for him to express his willingness to accept conditions to be admitted to the panel. There is free choice within the panel in every locality. A continuous increase in the costs of medical care and a steady rise in morbidity are characteristic of practically all systems. There is much controversy over the question of certification. The Majority Report of the Royal Commission of 1926 reported that ultimately the medical service would have to be divorced from the insurance systems. The Minority Report stated that "it is undesirable to retain Approved Societies any longer." However, the political power of the Approved Societies, which act as carriers of insurance, is so great that no serious move has been made to carry out these recommendations.

In the beginning the importance of the medical profession to the insurance system was but little recognized, but as the medical service came to be looked on as far more important than cash benefits the position of the physician gained in importance. In the later systems the physicians have obtained more of a voice in the control of medical service. There is much disagreement as to the incomes of physicians under insurance. In the British system the gross average amounts to about \$2,000 a year. At present the points of conflict are payment and lay control. Under the latter are the questions of restriction of prescribing, free choice, professional secrecy, expensive "red tape," entrance to insurance practice, the operation of clinics, and certification for cash benefits.

Special dental problems under insurance are treated. In most of the continental systems some sort of dental care is given as a part of the regular insurance service. In Great Britain it is an additional benefit given according to the financial condition of the society.

Insurance has had important social effects. It apparently tends to increase the amount of sickness, although the defini-

tion of sickness under insurance is such as to make comparisons between nations or even years difficult. A certain amount of this increase is thought to be due to neuroses created by the existence of cash benefits and the ability to receive medical service without cost. After the insured has made payments for several years, he has a strong desire to get something back, which may lead him to malingering or more often may be the actual cause of neuroses.

The United States has developed nearly all the conditions that have preceded sickness insurance in nearly all other countries; it has extensive systems of contract practice and in workmen's compensation has developed many of the features characteristic of European systems of sickness insurance.

In the conclusion it is pointed out that there is a general agreement that there should be a complete separation of service and cash benefits; that insurance has a tendency to spend its resources on minor diseases rather than the more important. The evils of insurance appear to decrease in proportion to the degree that responsibilities, with accompanying powers and duties, are entrusted to the medical profession.

Insurance is only one possible way of providing for the distribution of costs of medical service. There is a possibility of expansion and development of other methods that may better perform the functions now assigned to insurance.

SICKNESS INSURANCE—AFFIRMATIVE

AGANAT, A.: OBSERVATIONS ON NATIONAL HEALTH INSURANCE, J. M. A. South Africa 3:35 (Jan. 26) 1929.

From an economic standpoint, the health of a nation is of paramount importance to its progress. Every industry, business or occupation suffers considerable financial loss by ill health of its workers. The health of a nation is of vital concern to its government, good health an asset of the greatest value, and as an asset which can be attained it becomes a national responsibility requiring the same care bestowed on it as any other sphere of government work. Practically every government of the present day has its special department and minister dealing with health matters. Some countries have a fairly comprehensive and exemplary scheme embracing the control and management of infectious diseases, sanitation and hospitals, providing also the necessary medical services to the industrial and poorer classes. The latter part of the program, i. e., medical attendance to the industrial and poorer classes, is a comparatively recent achievement, the success of which can be gaged by the working results of the national health insurance scheme of Great Britain. The medical profession has materially benefited considerably, and its position has been definitely strengthened. Strangely enough, a section of the profession was skeptical and reticent in acceding to the introduction of national health insurance in Great Britain, but time has justly altered this pessimistic anticipation, which was brought about by the success of the present system.

AMERICAN MEDICAL ASSOCIATION: NATIONAL MEDICAL SERVICE: EXTENSION OF MEDICAL SOCIALISM, London Letter, J. A. M. A. 94:1612 (May 17) 1930.

The national health insurance act was a great step in medical socialism and in spite of its grave defects, medical socialism is being extended. Another great step is the systematic medical inspection and treatment of school children, and the child and maternity welfare schemes. The whole trend of legislation in recent years has been socialistic and a socialist government is now in power. For a long time the British Medical Association has been studying the question of the formation of the "Public Medical Service Association" to establish a medical service available to every person, so as to bring the views of the profession to bear on the developments that must take place. The council of the association has now produced a scheme to provide a service available for every class and covering the

whole field of preventive and curative medicine, which it presents to the public and of which it invites the fullest criticism. It claims that its scheme has the advantage which many schemes already submitted to the public lack—that it is in accordance with the beliefs and traditions of the medical profession and would have its whole-hearted support. It must not be concluded that the production of this elaborate scheme is due to any desire of the medical profession or of the British Medical Association for the extension of medical socialism. The great step of the national insurance act was bitterly opposed by the profession and still is anathema to a section of it. The scheme has been brought forward because the association regards this extension of medical socialism as inevitable and wants to be early in the field, so that the change shall be, as far as possible, on lines acceptable to the medical profession. Other schemes have not been brought forward with any corporate medical support or consultation with the profession. The few physicians responsible for them are socialists.

AUBRUN: SOCIAL INSURANCE IN ALSACE AND LORRAINE,
Paris méd. (Annexe) 1:v (April 20) 1929.

In order to lead to a better understanding of the social insurance system in France, Aubrun gives a brief analysis of the system as it has been established for many years in Alsace and Lorraine. In contrast to the unity of the French system, there are three kinds of insurance provided for: Sickness Insurance, Accident Insurance and Invalidity and Survivor Insurance. Sickness insurance is either compulsory or optional, depending on the salary received. For purposes of assessment the workers are divided into nine classes, which is also in contrast with the French method of assessment. The benefits of sickness insurance include illness, pregnancy, funeral indemnity and assistance to families. Accident insurance is composed of two branches, industrial and agricultural. The industrial insurance is administered through corporations and employees in much the same way as sickness insurance. The agricultural corporations however, are far more complex and loosely organized. Assessments are proportioned among the members at the end of each year according to the amount of money spent. Both assessments and benefits vary with the kind of labor done, the risks involved and the average wages. Invalidity and survivor insurance includes benefits rendered because of old age or disability and to widows and orphans. As in the case of sickness insurance the administration of the fund is entrusted to a committee composed of government representatives as directors together with representatives of employees and workers.

BERTELSMANN, R.: IMPROVEMENT OF SOCIAL INSURANCE, München. med. Wchnschr. 76:205 (Feb. 1) 1929.

Bertelsmann believes that the practice of social insurance could be improved by making all sickness insurance a form of endowment insurance. For every insured person an endowment fund would be set aside to which would be added 80 per cent of the money paid in by him plus interest and compound interest. A person who never made use of the social insurance clinic would receive at the age of 60 years, provided that he had previously become incapacitated for work, the entire amount. If he then desired he could leave the money with the social insurance society to draw interest, with the privilege of withdrawing it at any time. If he used the social insurance clinic for drugs or sickness benefit his endowment fund would be reduced accordingly. At the end of each calendar year he would receive a statement of his account from the social insurance society. The 20 per cent held by the insurance society would be used in cases in which either because of the youth of the member or because of a severe, prolonged sickness the member's fund would not suffice. If a member not incapacitated for work left the society before he was 60 years of age and had previously not required medical treatment he would receive credit for 80 per cent of the payments plus interest and compound interest, which he would receive at the age of 60 years. The advantages of this plan are that the man who consults the physician unnecessarily spends his own money whereas the man who does not is just so much richer at the end of every working week.

BRACKENBURY: STATE INSURANCE, J. M. A. South Africa 2:270 (May 26) 1928.

When a country has reached a certain state of intelligence it becomes the duty of the government to take an interest in the sanitary arrangements, in medical officers of health, and in provisions such as medical treatment; and if the government makes up its mind, after duly submitting such a scheme to the electorate, to provide for people not able to provide for themselves, then it is no part of the medical profession to oppose it, or any action of the government in making these provisions. For what we have to do as a profession, when the government is inquiring about such a system, must be to try and make suggestions as to the kind of system to be introduced, and work out the details of the system which will be acceptable to the public and the profession. There can be no doubt that the service under the insurance act of Great Britain is of great benefit to the public and also to the profession. As far as the public is concerned, there are large numbers of people who

now get medical treatment who under the old scheme of things did not get it. It has enabled physicians to settle in poor industrial areas and conduct quite a good practice. The aim has been to approximate this system to the conditions of private practice. It is the right of every physician to participate in the system if he cares to stick to the conditions, but there is no selection; every registered medical practitioner can take part. The next thing was to allow the free choice of every patient to choose his own physician, but it is, again, the right of every physician to say to a patient, "I do not wish to treat you any more." Always with this proviso, however: that in some areas the physicians are collectively responsible for all the insured persons in their area, and if there happens to be a conspiracy among the physicians of an area, and they say, "None of us will treat Tom Jones because we do not like him," then Tom Jones must be assigned to some physician who will be responsible for him. In Japan, the government says to the medical profession, "We are going to provide this money and place it in your hands, and it will be entirely your lookout to work out the details," and the profession then makes itself responsible to see that the work paid for is actually done. The whole responsibility of the administration of the work is placed on the profession as a whole, and I am told that so far the Japanese profession is fairly well satisfied with the responsibility that they have undertaken. In England we would not look at such a system. We have tried to keep the system as near as possible to private practice system. The alternate system is to set up a clinic in every suitable area, and the physicians come to that place at certain hours; but we want to provide family physicians for each insured person, and not set up institutions which each insured person will attend.

BROWN, P. K.: *INDUSTRY'S ANSWER*, Survey Graphic 16:398 (Jan.) 1930.

Health service can be obtained for industrial workers in only one way—that is, by distributing the cost. The factor that makes medical service more and more expensive is not the fees of physicians, which have failed to increase in the past twenty years as have the earnings of almost every other group, but the cost of laboratory investigation. The hospital system of the Southern Pacific Company is industry's answer to the demand of reformers for health insurance; and if legislation can do any great thing for the cause of health it will profit by the lessons of the private health insurance organizations of industry and protect them from the competition of over-advertised and poorly-run hospital benefit societies organized for profit, by standardizing service and keeping it in the hands of the regular medical profession. Industrial health service is not paternalism, but a method of distributing the excessive

costs of modern investigation to make it available to all groups. Private enterprise has a duty in pointing the way of which we are not unmindful. There is room for endowment of research, for the new problems are many, and medical research may not seem a just charge on industry. It has a strong appeal to the highest class of physicians, and it should be a part of every large hospital.

CANADIAN MEDICAL ASSOCIATION: REPORT OF THE COMMITTEE ON ECONOMICS, June 1934; also in Canadian Medical Association Journal, September 1934, pp. 25-63.

"This report was received by Council and passed to the provinces for their consideration. It is NOT to be interpreted as the opinion of the Canadian Medical Association on Health Insurance."

The principal methods of caring for the indigents and the middle class are surveyed. How to make available for every one the full benefits of curative and preventive medicine, irrespective of the ability of the individual to pay, and, at the same time, to secure the willing cooperation of the medical profession, is the problem.

There is a history of health insurance with the provisions for coverage, contributions, benefits, payment of physicians and administration. A survey of national health insurance in England and the Highlands and Islands of Scotland Medical Service and German sickness insurance is made. A summary of the British Medical Association's Proposals for a General Medical Service for the Nation and of the work of the Committee on the Costs of Medical Care, and the Bureau of Medical Economics' "Critical Analysis of Sickness Insurance" is included.

The conditions of an adequate medical service are set forth and some criticisms of health insurance are considered and discussed. Conditions in Canada are treated as a whole and then by provinces. The plan proposed for state health insurance in Canada recognizes that it must be handled by the provincial legislature, but it urges Dominion grants which might be used to secure the inclusion of uniform desirable provisions in all provincial legislation.

A fair criticism of health insurance is that it has not been preventive in practice and but little in outlook. The organized preventive and curative medical services should be fully coordinated and, for this reason alone, it appears essential that administrative responsibility for health insurance should be placed with the departments of public health.

Therefore, they conclude that state health insurance should be organized as a division in the provincial department of

public health. It is of fundamental importance that the control of the professional side of the medical service should be placed in the hands of the organized medical profession.

The health clinic is not practical outside the larger centers of population.

The plan is to have one organized medical service for the insured and the indigent, the state paying the insurance premium of the indigent.

Income limits are suggested of \$2,500 annually for a person with dependents and \$1,200 for one without dependents.

It is desirable to emphasize, through reiteration, that mass methods are not applicable to medical care, because medical care is the care given to an individual who is sick, and as neither individuals nor illnesses are ever exactly alike, they cannot be treated by mass or routine procedures.

These principles are summed up as follows:

11. That the only benefit under the Plan be the medical benefit;
12. That the medical benefit be organized as follows:
 - (a) Every qualified licensed practitioner to be eligible to practice under the Plan;
 - (b) The insured person to have freedom of choice of general practitioner;
 - (c) The medical service to be based on making available to all a general practitioner service for health supervision and the treatment of disease;
 - (d) Additional services to be secured normally through the general practitioner—
 1. Specialist and consultant medical service (only those so designated to be eligible to practice as specialist and consultant);
 2. Visiting-nurse service in the home;
 3. Hospital care;
 4. Auxiliary services—usually in hospital;
 5. Pharmaceutic service.
 - (e) Dental service, arranged direct with dentist or on reference.

The insurance fund would receive contributions from the insured, the employers of the insured, and the state.

The medical practitioners of each local area should be remunerated according to the method of payment which they select. No economic barrier should be imposed between the doctor and patient, but the insured should be required to pay a part of the cost of medicines.

There is quite an extensive bibliography.

REPORT OF THE COMMITTEE OF THE QUEBEC MEDICAL ASSOCIATION ON SOCIAL INSURANCE, *Canad. M. A. J.* 27:554 (Nov.) 1932.

In our opinion the "cover" should include all costs incidental to sickness; viz., medical attendance, nursing, hospitalization, drugs and supplies, and dental treatment. The indigent will continue to be treated according to the traditions of the medical profession, not by compulsion but as a privilege, without hope of material recompense. The large so-called middle class should benefit from this plan of insurance. Compulsory health insurance of this class of the community will correct these evils. The payment of the premium will have to be met; the individual will then be free to consult or call the physician without hesitation, and the physician will be paid, as well as the other incidental expenses.

It is our opinion that the well-to-do should not have the option of participating in a state plan of health insurance and thereby benefit from public moneys or from a tax on any one class or from the services of the medical profession at what would probably be a reduced fee under a schedule.

As members of the medical profession, we are particularly interested to demand that the existing relations between doctor and patient should be maintained, that the ethics of "professional secrecy" should be respected, and that "freedom of prescribing," with agreed restrictions, should be allowed.

That nothing suggestive of the contract or panel system should be introduced.

That the patient should have free choice of the doctor he desires to employ.

That a doctor should have free choice as to whether he desires to undertake health insurance practice or not.

That the doctor should be paid for the services he actually renders, according to a schedule of fees.

That the doctor should render his account to, and be paid by, the state (or commission).

That payment for treatment of the insured should be limited to duly qualified regular practitioners of medicine.

That in arbitration of any disputed point as between the contracting parties, viz., qualification of practitioner, fees, duration of illness, etc., the medical profession should be represented by the Province of Quebec Medical Association either directly or through a regularly appointed committee.

Sick benefits paid in cash must be protected against abuse by (a) the integrity and honesty of members of the medical profession; (b) in paying as sick benefits only one half or less of the average wage lost.

Maternity benefits, viz., a small cash sum paid to the expectant mother for the purpose of employing household help, is thus a valuable plan of social insurance. Maternity benefits

are paid in addition to those expenses for treatment, etc., incidental to the illness of childbirth.

In conclusion, your committee proposes the following recommendations to be submitted to the annual meeting in the form of resolutions:

1. That health insurance, as broadly interpreted in this report, and limited to a class or classes of the population whose annual revenue does not exceed a sum to be determined by further study, would advance the health and welfare of the people of the Province of Quebec.
2. That sick benefits are an essential feature of any health insurance scheme.
3. That maternity benefits are desirable to conserve the health of mother and child.
4. That a copy of this report be sent to the district societies and to all other organized medical societies in the province with a request for study, amendment or adhesion to the principles outlined in these resolutions and prompt report back to the executive of the provincial society, with recommendations.
5. That the provincial medical association be hereby constituted the authoritative body to represent the profession before the commission, presenting as evidence the majority opinion as expressed through the societies.

MEDICAL CARE FOR THE AMERICAN PEOPLE, THE FINAL REPORT OF THE COMMITTEE ON THE COSTS OF MEDICAL CARE, Oct. 31, 1932.

The Committee on the Costs of Medical Care gave a Majority, two Minority Reports, and two personal statements. The Majority Report made the following recommendations:

I. The committee recommends that medical service, both preventive and therapeutic, should be furnished largely by organized groups of physicians, dentists, nurses, pharmacists and other associated personnel. Such groups should be organized, preferably around a hospital, for rendering complete home, office and hospital care. The form of organization should encourage the maintenance of high standards and the development or preservation of a personal relation between patient and physician.

II. The committee recommends the extension of all basic public health services—whether provided by governmental or nongovernmental agencies—so that they will be available to the entire population according to its needs. Primarily this extension requires increased financial support for official health departments and full-time trained health officers and members of their staffs whose tenure is dependent only on professional and administrative competence.

III. The committee recommends that the costs of medical care be placed on a group payment basis, through the use of insurance, through the use of taxation, or through the use of both these methods. This is not meant to preclude the continuation of medical service provided on an individual fee basis for those who prefer the present method. Cash benefits, i. e., compensation for wage-loss due to illness, if and when provided, should be separate and distinct from medical services.

IV. The committee recommends that the study, evaluation and coordination of medical service be considered important functions for every state and local community, that agencies be formed to exercise these functions, and that the coordination of rural with urban services receive special attention.

V. The committee makes the following recommendations in the field of professional education: (A) That the training of physicians give increasing emphasis to the teaching of health and the prevention of disease; that more effective efforts be made to provide trained health officers; that the social aspects of medical practice be given greater attention; that specialties be restricted to those specially qualified, and that postgraduate educational opportunities be increased; (B) that dental students be given a broader educational background; (C) that pharmaceutical education place more stress on the pharmacist's responsibilities and opportunities for public service; (D) that nursing education be thoroughly remolded to provide well educated and well qualified registered nurses; (E) that less thoroughly trained but competent nursing aides and attendants be provided; (F) that adequate training for nurse-midwives be provided, and (G) that opportunities be offered for the systematic training of hospital and clinic administrators.

It laid down the essentials of a satisfactory medical program to be the following:

1. The plan must safeguard the quality of medical service and preserve the essential personal relation between patient and physician.

2. It must provide for the future development of preventive and therapeutic services in such kinds and amounts as will meet the needs of substantially all the people and not merely their present effective demands.

3. It must provide services on financial terms which the people can and will meet, without undue hardship, either through individual or through collective resources.

4. There should be a full application of existing knowledge to the prevention of disease, so that all medical practice will be permeated with the concept of prevention. The program must include, therefore, not only medical care of the individual and the family but also a well organized and adequately supported public health program.¹

1. The term "public health program" is meant to include the work of the official health departments and of voluntary health agencies.

5. The basic plan should include provisions for assisting and guiding patients in the selection of competent practitioners and suitable facilities for medical care.

6. Adequate and assured payment must be provided to the individuals and agencies which furnish the care.

In organizing the services it declared that "the keystone of the concept of a satisfactory medical service for the nation is the development of one or more nonprofit 'community medical centers' in nearly every city of approximately 15,000 population or more." Within the medical center, the rôle of the family practitioner would be prominent and respected.

The cost of the service provided by a medical center, branch or station would vary in different communities because of differences in (1) the adequacy of existing facilities and the necessary expenditures for new land, buildings or equipment, (2) the compensation to practitioners, which would depend in part on the costs and standards of living, and (3) the degree to which various refinements of service would be expected and required by patients.

In explaining its plan for insurance, the committee recommends that organized groups of consumers unite in paying into a common fund agreed annual sums, in weekly or monthly installments, and in arranging with organized groups of medical practitioners working as private group clinics, hospital medical staff or community medical centers to furnish them and their families with virtually complete medical service.

It urges that local governments aid health insurance and that state and federal aid be supplied under certain conditions. Several members of the Majority group believe that required health insurance will eventually be necessary and urge a governmental system.

It is estimated that the maximum figure, \$3.25 per month, while not greatly higher than present average per capita expenditures, could provide service of substantially larger volume and better quality than the wage-earning population now usually receives, and could furnish funds for adequate remuneration of practitioners.

COX, ALFRED: SEVEN YEARS OF NATIONAL HEALTH INSURANCE IN ENGLAND, J. A. M. A. 76:1350 (May 14) 1921.

The introduction of the insurance system has more than doubled the work and responsibilities of the British Medical Association. It is only fair to say that since we forced ourselves on the attention of the government at the introduction of the first bill, they have never, with one small exception (not worth mentioning except to show that without constant vigi-

of regulations. It is one of the normal duties of the insurance acts committee of our association to meet the representatives of the Ministry round a table for this purpose. In the extensive revision of regulations which followed the armistice, we met thus in conference no less than twenty-three times. When we had roughed out the main lines on which the changes were to be founded, we circularized every insurance practitioner in the country, telling him the result of our labors. Then we had a conference of representatives which discussed the proposals thoroughly. Then we went back to the ministry, had more discussions, and finally the ministry embodied the changes in actual draft regulations which we put up to another conference. Now I do not say that the ultimate result was that we got all we asked for, or secured the elimination of all we objected to, or the agreement of all our constituents. It did not. But I am prepared to say that we succeeded in getting inserted in the new regulations a good deal of what we wanted, and eliminated many things to which we objected, and that the regulations as they finally emerged were a creditable production of collective bargaining. It is true that a government department holds a strong position. It has all the force of the government behind it and it holds the purse. But the medical profession also holds a strong position. Without it, no service can be provided and the government is bound to provide a service. Even if the profession is not strong or united enough to refuse service, the heads of a government department know that a dissatisfied service is a bad service, and that a bad service has a knack of proving awkward for the politicians and is just as awkward for the people who serve the politicians. Moreover, civil servants are reasonable persons who have a pride in the success of their department. A dissatisfied service means constant friction and more work for them. Therefore, they are prepared to go a long way to meet the responsible negotiators for the profession, who are, presumably, also reasonable persons, as equals. The regulations are administered locally by the insurance committee, which is composed, taking one of the larger bodies say of a county, of sixty persons. Twelve of these are elected by the county council, of whom two must be doctors; thirty-six are representatives of the insured persons; ten are nominated by the ministry of health, of whom at least one must be a doctor, and two are nominated by the panel committee, both being doctors. Thus, out of sixty members there must be at least five doctors and there may be one or two more. The weak spot is the insured persons' representatives, who are generally officials of the approved societies, and whose method of election is frequently by no means ideal from the representative point of view, owing to great differences in the constitution of the approved societies into which I need not enter. The insurance committees are not bodies whose composition could be recommended to other countries proposing to set up similar bodies. Nobody in this country believes them to be a

permanent institution; but they have done much good work under great difficulties, and we have no reason to be ashamed of them. The insurance committee distributes the money (sent to them by the ministry of health from the central fund) to the doctors in accordance with the numbers of persons on their lists. It is responsible for the adequacy of the local service both of doctors and of chemists. It is responsible for the administration of sanatorium benefit for tuberculous persons, though often sharing this with the county council or county borough council, to whose hands it will shortly go altogether. It has nothing to do with the administration of sickness or maternity benefits, money payments which are the province of the Approved Societies. Each insurance committee must have a medical service subcommittee composed of an equal number of representatives of doctors and of insured persons, with a chairman who must be a member of the insurance committee but must not be either a doctor or an insured person's representative. To this subcommittee are automatically referred all complaints by patients against doctors and by doctors against patients. The report of the subcommittee must go to the full committee, but it is rarely that the report is not accepted, frequently without discussion. It is a fact, not foreseen by many of us in the earlier days, when we viewed the setting up of these bodies with great suspicion, that the medical members of the subcommittee are notoriously much harder on medical delinquents than the lay members are. The penalties on the doctor are prescribed by the insurance committee on the recommendation of the medical services subcommittee, and they may vary from censure to the recommendation to the minister of health that a part of his capitation grant be withheld as a punishment, or that he be removed from the list. The doctor has the right to appeal to the minister. In any case of suggested removal from the list the case must be heard by an independent lawyer and two nonofficial doctors appointed as a court by the minister. They report their findings to the minister, whose decision is final. The original 1911 act recognized a local medical committee in every insurance area where the profession cared to elect one. The only condition laid down about its composition was that the insurance commissioners should be satisfied that it was representative of the qualified medical practitioners of the area, after passing which test it must be consulted by the insurance committee on all general questions affecting the administration of medical benefit, and the arrangements made with the medical practitioners. In some areas the doctors did not elect local medical committees; and as some such committee was essential, the act of 1913 provided that this local consultation must take place through a committee (called the panel committee) appointed by practitioners who are actually doing insurance work and elected in accordance with regulations made by the insurance commissioners. Both the local medical committee provided under the 1911 act and the

panel committee set up under the 1913 act are in existence still; but in every area the personnel is the same. The panel committee is the body which directly represents the interests of the insurance practitioners in every area. There is a considerable amount of elasticity as to the methods by which the panel committee is elected. The only rôle of the ministry of health (vice the insurance commissioners) is to satisfy itself that, when elected, the panel committee may be taken as representative of the insurance practitioners in the area. Other duties have recently been placed on the medical profession, which are exercised through an allocation subcommittee, composed of equal numbers of persons appointed by the insurance committee and by the panel committee. The duties of this body are to see that all insured persons get the medical benefit to which they are entitled, if necessary by allocating them to one of the doctors on the list. There are many insured persons who, in spite of repeated reminders, will not choose a doctor. This subcommittee may, after due notice, proceed to allocate them to some doctor or doctors (this power has not yet been exercised). Sometimes a doctor or doctors will decline to accept a certain person for reasons which seem good to them, and the allocation subcommittee may have to allocate him to another, or even to one of those who has refused. But this is rare. Allocation is not often required except for strangers who have come to the district and find some difficulty in getting accepted. This kind of allocation, however, is generally done, not by a meeting of the subcommittee but by the operation of a previously arranged scheme, or by arrangements made by the clerk of the insurance committee with some conveniently situated doctor. The chief duty of the subcommittee (which only came into existence in 1920) is to allocate those persons who have been on the list of a retired or deceased doctor, and who, after due notice, do not choose a doctor for themselves.

DAVIS, MICHAEL M.: THE AMERICAN APPROACH TO HEALTH INSURANCE, Milbank Memorial Fund Quarterly, July 1934.*
Reprint from the Rosenwald Fund.

The British and German systems of health insurance were developments of their time and laid their strongest emphasis on cash relief. It is clear that the approach is economic. Social insurance, according to this conception, is to be set up as protection against the impairment of earning capacity. Developments in medical service, especially in preventive and hygienic lines, have changed the attitude and caused medical care to be considered of prime importance. The problem of wage-loss should be approached as one of the economic insecurities which is properly to be dealt with by social insurance but should be fitted in, financially and administratively, with phases of social insurance that are primarily economic, such

as unemployment insurance, or as an extension of industrial accident compensation. We should therefore move forward with plans for action directed primarily toward an adequate system of curative and preventive medical services.

DESTOUCHES, L. F.: SOCIAL INSURANCE AND POLITICAL ECONOMY OF PUBLIC HEALTH, *Presse méd.* **36**:1499 (Nov. 24) 1928.

Destouches deplors the tendency to regard the system of social insurance as essentially a humanitarian enterprise. Its purpose is primarily economic: that of permitting a better utilization of human material in industry. The author attributes the failure of the system both in France and in other countries to the fact that the subject has not been frankly analyzed and organized from the economic standpoint. He presents the following basic principles that should underlie the organization of a system of social insurance: 1. That the insured should work as much as possible with the least possible interruption because of sickness. 2. That most invalids are able to work. 3. That the invalids should receive treatment and care for themselves while they are working and thus utilize all the opportunities offered by modern industry for the employment of invalids. In order to extend the field of preventive medicine and hygiene and to give proper medical care to the workman at the scene of his work a new class of physicians should be created, that of traveling industrial consultant physicians, who would daily come into intimate contact with the workmen in the industrial organizations of the nation. In this connection the author condemns the results of the system of visiting nurses both in the home and in industry, since nurses do not have sufficient reliable scientific knowledge to give advice to credulous people who are only too ready to accept any suggested method of treatment. The industrial consultants should be not only physicians but also sociologists and students of practical philosophy if they are to succeed in combating the tendency of the people to exaggerate their symptoms, to imagine themselves ill and demand treatment for every whim. A veritable police force of health officials should be established, which should include, first, the physicians in charge of dispensaries, hospitals, and patients confined to their homes and, second, traveling industrial physicians to safeguard the industrial life of the nation. The advantages of such a system to the employers are even greater than the benefits to the workers. Instead of maintaining a costly system of medical examination to eliminate from service those not in perfect health; instead of having to contribute to the cost of furnishing support and medical care for great numbers of unemployed who could easily do an ordinary day's work, and instead of being constantly annoyed by workers losing time because of illness, under an efficient

social insurance system the majority of workers would work all the time and the necessity for medical care would not involve loss of time and money. In addition, through such unified and intelligent organization of the public health service, general hygienic conditions would gradually improve so that the actual proportion of sickness among workers would eventually be diminished.

FINKENRATH, KURT: CARE FOR HEALTH OF INSURED POPULATION, *Klin. Wchnschr.* 8:848 (April 30) 1930.

The coordination of activities of the German health insurance societies was the result of regulations enacted by the federal government. The regulations were elaborated at meetings of delegates of health insurance societies, of accident and invalidity insurance societies, of federal insurance, of insured persons and of physicians. Physicians were invited to the meeting. Enforcement of the regulations was entrusted to the societies. Tuberculous patients with a sexual disease were chiefly considered. Sickness funds must provide medical care and medicines to insured tuberculous patients, care in sanatoriums or convalescent homes and proper care at home. Their help includes also adequate food, clothing and housing. Measures for prevention and for struggling with tuberculosis should be advertised. Loans enabling acquisition of a proper home are provided. Hospitals and sanatoriums for the tuberculous must be accessible to physicians, medical students and nurses desiring to specialize in treatment and in care of tuberculous patients. Foundation of consultation centers and advertisement of measures for prevention and of treatment were included in regulations for patients with venereal diseases. If the patient is not willing to reveal the nature of his disease to the sickness fund, the latter pays for his treatment. There are regulations concerned with persons insured against sickness, invalidity or professional inability, whereby spouse, children, widow, widower and orphans are considered as co-insurers. The regulations took effect, April 1, 1929.

FINKENRATH, KURT: RATIONALIZATION OF SICKNESS INSURANCE WITH REGARD TO SICKNESS FUNDS, *Deutsche med. Wchnschr.* 54:1893 (Nov. 9) 1928.

The plan of rationalization or of reforms of the sickness insurance institution was formulated by the director of the main union of the sickness funds. Further improvements and extension of activities were the salient features of the plan. The reforms of the organization consist in centralization of its financial resources, a uniform distribution of expenses, and

simplification of the management. While up to the present time a sickness insurance society could be or could not be a member of the main union, in the future its incorporation in a local and then in a central association must become compulsory. These associations form the federal association. The latter has the right to control the activities of the associations and of the sickness funds. Enactments of sickness insurance funds and of sickness insurance societies must be approved by the federal association. The associations elect fifteen members into a central committee, which elaborates directive instructions for their activities. The expected extension of the activities consists in a compulsory insurance of every worker earning 6,000 marks a year and insurance of holders of a social or of any other small pension, of voluntary insurers and of independent persons. Thus the class insurance would become transformed into a national insurance. An insured person is entitled to cash payments necessary for the support of the family during his sojourn in the hospital, to proper care at home, to hospitalization of his dependents, to sickness cash up to fifty-two weeks, to medical treatment of members of the family up to thirteen weeks, and to cash amounting to 85 per cent of the wages for six weeks previous to childbirth. The suggested measures of economy are the following: Sickness payments should be allowed only to patients whose working incapacity has been ascertained on a thorough examination. The payments can be obtained only after the lapse of three days. An insured person whose working capacity proves completely restored after sickness must refund up to one fourth of the expenditure for medical care and for medicines. Entrusted physicians should determine the degree of the working incapacity and consequently the amount of compensation. The number of cases treated by a sickness fund physician ought to be limited; consequently his income will be reduced. The measure tends to avert unnecessary calls on the sickness fund physician. An extensive study of problems of the sickness fund physician and of the social insurance situation is required.

FINKENRATH, KURT: REFORMS OF SICKNESS INSURANCE, *Deutsche med. Wchnschr.* 55:1889 (Nov. 8) 1929.

Reforms in sickness insurance have been discussed at meetings of local and central sickness fund societies, at meetings of physicians, of industrial and of professional men, at meetings dealing with social reforms, and in the press. To the plan of reorganization presented last year, the director of the main union added some details at a recent meeting in Nuremberg. The number of the sickness fund centers ought to be reduced; the activity of local sickness funds must be uniform. Incorporation of sickness funds in associations and then in unions must

be compulsory. The plan of reforms includes obligatory insurance of every person with an income of 6,000 marks a year. Noninsured persons receiving a small annuity and unemployed persons with a small industry or with a small property in land should become members of the sickness funds. An improvement in provisions for the insured includes, among others, sickness payments up to fifty-two weeks, medical services for noninsured dependents up to thirteen weeks, household expenses and hospitalization. So far the attempts of the main union of German sickness funds to spread social education among insured persons has remained ineffective. It is planned to include physicians in the attempt to correct abuses in the sickness insurance organization. Reorganization of services of the sickness fund physicians was included in the reform. Entrusted physicians should ascertain working incapacity of the insured. They must cooperate in diagnosis and treatment. The sickness fund physicians ought to be held responsible for expenses caused to the sickness fund by needless treatment. Obviously there were objections to some of the reforms at medical meetings. With regard to venereal diseases, the following is suggested: Consultation centers must be informed of every case occurring in an insured person or in a member of his family. On notice, the insured or his dependent affected with a venereal disease must call on a physician of the sickness fund or come to the consultation center and follow prescriptions exactly. A sickness fund physician must inform the consultation center of any case of venereal disease occurring among the insured or their dependents. The consultation center will provide specialists. The treatment of a syphilitic patient may be repeated three or four times. Physicians are selected by the committee of a district insurance fund. The federal government appears to be inclined to entrust private insurance companies with the sickness insurance of the unemployed, because they are able to suggest more favorable conditions than the sickness funds. The tendency to large dividends on the part of the stockholders may cause more financial harm to the physician than the tendency to economy on the part of the sickness funds.

HANAUER, W.: ECONOMIC CONDITIONS OF PHYSICIANS IN
FRANKFORT, *Deutsche med. Wchnschr.* 51:1453 (Aug. 28)
1925.

The author first discusses a prescription pamphlet for insurance practice. He states that the booklet not only differentiates between cheap and expensive remedies but also gives the reason for its rules by citing the decisions of well known authorities. Some physicians might accept this: but those who are more critical will realize that the opinions about new remedies are

usually divided in the beginning. The author points out that many organizations of insurance physicians have each their special prescription booklet. He deplores this as a waste of time and money, and suggests the publication of a booklet that may be used by all insurances throughout Germany. In the second part of his paper the author discusses the economic conditions of physicians. In Bavaria pensions for physicians are regulated by the state. In Frankfort-on-the-Main, as also in the province of Hesse-Nassau, insurances providing pensions for old age, for invalidism, and for the relicts have also been established. The premium amounts to 6 per cent of the income from insurance practice and from private practice. Out of these premiums the various pensions are paid. That this insurance system is necessary is proved by the deplorable economic conditions in which some physicians and their dependents find themselves.

HATTON, JOHN: TREATMENT OF INSURED PERSONS, M. Press 124:285 (Oct. 5) 1927.

The real beginning of any active movement to make spa treatment available for the insured population of this country, dates from the publication, in 1924, of the Report of the Ministry of Health on "The Incidence of Rheumatic Diseases." The efficacy of spa treatment is indicated by the gradually increasing use made of it by the medical profession and in particular by the statistics of the mineral water hospitals. The average of patients discharged as cured or relieved at the hospitals at three of the principal British resorts in recent years is 87 per cent. In the hope of doing some practical thing to lessen national invalidity from rheumatic diseases, the British Spas Federation, in 1925, drafted a skeleton scheme for spa treatment for insured persons, and this scheme has been the basis of all subsequent discussion and development. The scheme aims at utilizing existing machinery, extending it where necessary, and linking together the various organizations which have been carrying on successful work, handicapped often by financial and other restrictions, limited by isolation and lack of cooperation and mutual help. The proposal is that spa treatment should be made available for all persons insured under the National Health Insurance Act. Judging from various official statements, the attitude of the Ministry of Health appears to be entirely sympathetic, and there are good grounds for expecting that a request from approved societies for the benefits of spa treatment for their members, to be sanctioned as an additional benefit, would receive favorable consideration from the ministry. Patients would be recommended for spa treatment by their home panel physician. A history and report of each case would be drawn up by the panel doctor and sent for the consideration of the medical board at the spa to which the patient is recommended. If the spa

medical board decided that the case was suitable, the patient and his doctor would be notified. A similar method of selection is found to work satisfactorily in connection with spa hospitals, and, provided clear information is given to the panel practitioners, it should prove effective on the larger scale. The spa to which a patient would be sent would generally be determined on a geographic basis. The number of insurance patients who could be treated at the respective spas depends on the seasonal demands on the bathing establishments by their present ordinary visitors. With the present available facilities, it is estimated that an average of at least 2,000 patients could be undergoing treatment at one time. The average duration of a course would probably be from three to four weeks, so that 30,000 patients a year might easily be treated. The best medical advice possible is essential to secure the full benefits of any scheme for dealing with rheumatic diseases on a national basis, and at the spas the experience of a group of specialists would be available. While this scheme is primarily intended as a treatment scheme, the far-reaching possibilities offered for research by this vast amount of fresh clinical material have not been overlooked. By adding to the existing in-patient wards of the hospitals what would actually be an elastic outpatient department, and linking up with the research machinery of the hospitals (working, perhaps, in suitable cases in cooperation with a university), there is every opportunity for teamwork in both research and treatment, the whole combined organization providing in a large measure the threefold scheme advocated, in 1925, by the report of the chief medical officer of the Ministry of Health. The investigation would go hand in hand with curative measures which Dr. Fortescue Fox laid down at the conference on rheumatism at Amsterdam in 1926 as one of the essentials in the belief of the International Society of Medical Hydrology. Patients would attend at a consultation center on arrival, and as often afterward as the physician in charge of the case required, and full records of the cases would be kept. The treatments would be given at the bathing establishments at hours to be arranged, an inclusive capitation fee being charged. No restrictions would be made, and the physician in charge of any case would be able to order baths and douches, the drinking of the mineral waters, massage, and electrical and other accessory treatments up to the full limit most effective in his judgment to secure the quickest and most lasting benefit. Patients would be required to observe certain rules as to general behavior, hours of returning to lodgings, not obtaining outside refreshment, and the like. Patients might sometimes be accompanied by a member of their family. This would present no difficulty under the "approved boarding-house scheme." The railway companies might reasonably be asked to issue tickets at specially reduced fares to insured persons traveling to spas for treatment under the scheme. At each spa a local controlling body should be established—a National Health Insurance Spa Council, or

some such title—consisting of representatives of the corporation, or other authority controlling the spa, the medical board, the supervisory committee of the approved societies, the spa hospital and the local insurance committee. The medical board would control all medical matters, and advise as to the suitability of applicants for the medical staff, which would bear a proportion to the number of patients to be expected. The corporation, or other spa authority, would be responsible for administration and would receive applications, which would be submitted to the medical board and notify the applicants of their decisions. The British Spas Federation, as the body linking together the spas, would act as a general liaison between the various spa councils, the approved societies and the Ministry of Health.

HIGGINS, T. S.: MEDICAL TREATMENT AS SOCIAL PROBLEM, *J. M. A. South Africa* 4:158 (March 22) 1930.

It is unfortunately a fact that for large sections of the population of this country the medical service that is available is most unsatisfactory and incomplete. This is not due to the limitations of medical science, but to the circumstance that for economic and other reasons the resources of medicine are not made available. This is a problem that has faced the poor of all countries, and in some of them the working classes have in the past tried to meet the position by the formation of friendly societies and sick clubs; that is to say, by voluntary insurance. By this means, the working people were able, when they were well, to build up funds for the assistance of their members in time of sickness. The clubs, by competition and bargaining, were able to get the services of medical practitioners at low rates. It is now nearly a century since the first friendly society was established in Britain; and in a few countries (Denmark and Switzerland are outstanding examples) voluntary insurance subsidized by the state is the basis of the national scheme for the provision of practitioner services. In Great Britain, although compulsory national health insurance is in operation, there are still (1922-1923) more than seven millions of people insured in voluntary sickness insurance societies, amounting to 18 per cent of the total population. In South Africa friendly societies have not taken a strong hold. There are 108 of them, and their membership (1926-1927) comprises less than 70,000 people, their funds amounting to rather more than half a million pounds. The average annual cost of medical attendance is £1 1s. 10d. a member. Compared with the voluntary friendly societies the Railways and Harbours Sick Fund, membership of which is compulsory on all white railway employees, assumes large proportions. The total membership is 41,500, and the members and their dependents are estimated at 125,000. The members' contributions are from 1s.

9d. to 15s. 6d. a month, the average being 7s. 3d., and the railway administration adds £75 to every £100 thus contributed. Of the annual expenditure (1927-1928), of £343,146, the railway medical officers received £99,611, other physicians £26,720, while the cost of medicines and medical appliances was £41,679, and of hospital services £62,512. Sick pay costs £97,732. The railway medical officers, each appointed to a district, are paid on a capitation basis, which varies according to locality and is usually 8d. or 10d. a month. The International Labor Organization of the League of Nations has drafted conventions (1927) binding states that ratify them to set up compulsory sickness insurance schemes in terms of the draft conventions, applying to all manual and nonmanual workers including, subject to certain exemptions, those engaged in industry, commerce, agriculture and domestic service. The International Labor Organization has also (1927) issued recommendations in regard to the general principles of sickness insurance. In this document it refers to the value of social insurance in obviating and making good any loss of the productive efficiency of the working population. The Commission on Old-Age Pensions and National Insurance—as a result of whose labors a system of old-age pensions is now in operation in this country—issued their report on sickness insurance in 1928. It contains definite recommendations for the institution in this country of a system of sickness insurance to provide sickness, medical, funeral and maternity benefits for workers in industrial areas. It proposes to include only those employees who are employed within the areas of urban local authorities, including municipalities, village councils, village management boards and health boards (unless especially exempted by the government), and such other areas as the government may proclaim. The scheme is not to apply to the rural districts generally, and employees engaged in agriculture, even in the urban areas, are to be excluded. Subject to these limitations, all employees earning not more than £400 a year, without any restriction as to age, are to come into the scheme, including manual and nonmanual workers, apprentices, outworkers, domestic servants and casual and seasonal workers. Employees earning not more than £60 a year are to be excluded if the minister is satisfied that proper provision is made by the employer for hospital and institutional accommodation and medical benefits. Employees will not be exempted on the ground that they are members of friendly and benefit societies. It is proposed that medical benefit shall be available not only for insured persons, but also for their dependents. The commission does not express any definite opinion as to the method of application of medical benefit. It does not even make a decision as between the panel system and the employment of a medical staff at fixed salaries. The commission intimates that it considers that the medical profession should show an interest in the scheme, and it hopes that before the time arrives for a bill to be drawn up the profession

will furnish the government with its considered opinion. It suggests that provisional agreements should be entered into with the medical and pharmaceutical professions before a bill is drafted. The question of the medical care of the people forms part of the general social and economic problems of the times. Urgent though they are, it is a mistake to consider them as abstract medical questions divorced from economic and social considerations. We know that the social and economic state of large sections of the population is the immediate cause of an enormous mass of sickness and mortality. An examination of vital statistics shows that the state of health to which the classes more favored in their social conditions have attained is far superior to that obtaining among those who are socially degraded. In any state, no matter how prosperous its laboring classes, the provision of services for the proper medical treatment of its people is of the utmost importance. But such provision should go hand in hand with measures for the building up of health and the prevention of disease; and among the most important of those measures is the securing of such an economic standard for its working classes as will enable them to rise to that level of comfort and culture which is a necessary condition of healthy living.

KAUFMANN, P.: FUTURE OF GERMAN SOCIAL INSURANCE,
Klin. Wchnschr. 4:27 (Jan. 1) 1925.

Compulsory enforcement of the Dawes plan may result, among other fields of activity, also in reduction of social insurance. Because the need of welfare in Germany is more acute than ever before, reduction of social insurance at the present time might prove to be disastrous. In reorganization of social insurance, the economic situation of Germany, on one side, and the increased need in welfare, on the other side, should be taken into consideration. The budget of social insurance amounts to one and a half billion gold marks a year. With regard to the national revenues, the social taxation, compared with that of the prewar time, has considerably increased. Hence rigorous economy is required; in other words the maximum of results ought to be obtained with as little expenditure as possible. Prevention of injuries proved to be less expensive than compensation for an injury. Like private insurance companies, social insurance grants compensations in the form of cash payments or a pension. In his work which was reported shortly before the outbreak of the World War, the author emphasized the fact that before the war the activity of insurance institutions was chiefly concerned with health welfare. After the war it became more concerned with matters of compensation. A return to the prewar character of social insurance is indicated. Cash payments, especially pensions, are less important than

proper sanitary and social measures. Preservation of health and of working capacity is the main purpose of social insurance. In case of an occupational accident, resulting in a partial or a total loss of working capacity, aid is first provided by the sickness fund, for fourteen weeks; then the care of the insured is taken up by the cooperative association. The care provided by the association continues until the patient is discharged. In case of an incomplete restoration of the working capacity, the cooperative association grants a pension. Such provisions are uneconomic and undesirable from any point of view. The method of dividing medical help between the sickness fund and the cooperative association is disadvantageous because the results of uniform medical treatment are more rapid and more complete. The change of physician and the repeated examinations influence unfavorably the patient's will to recovery; there may be a tendency to exaggeration or to simulation of the disease. Pensions ought to be abolished in cases in which the occupational incapacity is insignificant. Kaufmann suggests that medical care be provided by a cooperative association from the beginning of an accident, such are cases of severe injury, most frequently bone fractures. Cases of mild injury should be cared for by sickness funds. It is further suggested to abolish small pensions, because their economic value is insignificant. Money thus saved ought to be used for economic restoration of the accidentally injured. The method of care for the injured ought to resemble that given by federal welfare to the war injured. Money saved by sickness funds through reduction of expenditure ought to be used for medical treatment of the noninsured members of the family. The present tendency of social insurance to centralization should be combated. Simplification of the management and abolition of unnecessary instances are among the suggestions for reorganization of the social insurance institution.

LAMAZURE, ARTHUR: FEDERAL LEGISLATION AS REGARDS INSURANCE AGAINST DISEASE, ACCIDENT AND OLD AGE, *J. State Med.* 38:355 (June) 1930.

Arthur Lamazure presents briefly the most important features and characteristics of the legislation of Switzerland in what pertains to social insurance. The Swiss republic is a federation of twenty-five autonomous individual states, in and with which the legislative power is divided between the central government and the separate states, called cantons. The central government is competent for legislative power only to the extent that this competency has been expressly entrusted to it by the federal constitution. Accordingly, in any particular legislative department in which the central government is not competent, or as far as it has not made use of the legislative

powers conferred on it by the constitution, the cantons reserve the legislative powers for themselves. In the event that the central government has passed legislative measures within the scope of its legislative competency, then the cantons can enact laws in the same department only on the basis of and within the scope of such competency as may be imparted to them in the federal law. Considering the Swiss legislation on social insurance in the light of these general principles, one can first of all recognize the fact that the federal constitution has transferred to the central government the entire question of social insurance; that is, that kind of insurance which the state introduces through its own systematic methods, or at least with the help of its own resources for the protection of the human individual. The central government is competent to introduce sickness and accident insurance as well as old age, survivors' and invalidity insurance. Respecting the old age, survivors' and invalidity insurance, of which the introduction was not imposed on it until 1925, there is at present no legal ordinance as yet. Nevertheless, a federal law on old age and survivors' insurance is in preparation, which it is expected will be laid before the parliament before the end of the present year, whereas the invalidity insurance is postponed to a later date. The legislation pertaining to sickness insurance admits of being comprised in two main principles. First, the central government promotes the sickness insurance by subsidizing the approved societies, which are obliged to comply with certain prescriptions and as such stand under the supervision of the federal authorities. These prescriptions concern, in the main, financial security, the terms of admission, the kind and duration of the benefits given and the relations to the physicians. According to the second main principle the sickness insurance is fundamentally a voluntary matter, but nevertheless the cantons and communes are authorized to declare the insurance obligatory in a general way or for certain classes of the population. Quite a number of the cantons have thus far made use of this authorization in the most varied manner. Whereas in western Switzerland the cantons of Geneva, Vaud and Fribourg have confined themselves to introducing obligatory insurance for all school children, irrespective of the economic situation of the parents, other cantons such as Basle City, St. Gall, Appenzell and Thurgovia, as also quite recently Argovia, have introduced compulsory insurance for special categories of the population that are in straitened financial circumstances, mostly with the granting of special subsidies. In other cantons, more particularly in Zurich, the establishment of the obligatory insurance was initiated by the communes, as, for instance, in the city of Zurich. Of especial interest and of value from the standpoint of social hygiene is the solution which has been found in the Alpine valleys of the cantons of the Grisons and Ticino. Whereas, before the law went into force in these mountain valleys, medical assistance could not

be obtained at all or under almost unacceptable and expensive conditions on account of the topographic conditions, there have now originated in those regions public and private sickness insurance societies, to which the entire population of the commune or district belongs, irrespective of the state of property ownership, and these societies provide for medical attention and medicines for the patient through one or more physicians, who are appointed under contract. At the present time there are more than 1,000 approved societies, to which approximately 1.2 millions of insured individuals belong, a figure which represents about one third of the population of Switzerland. The property value of these societies, according to the statistics for the year 1927, amounts to 54 million Swiss francs, and for medical attendance and medicaments, for hospital stay and the like, approximately 22 million francs were expended in the stated year. On the other hand, the subsidies granted by the central government to the sickness insurance reached the figure of 7 millions. Whereas the sickness insurance represents a species of popular insurance that is, strictly considered, open to each and every citizen, the accident insurance has in a way the character of a system of class insurance, in that it is limited to the workmen and employees of such establishments in which the danger of meeting with accidents is especially great. If, accordingly, the sickness insurance is a voluntary matter in conformity with the federal law, the accident insurance is obligatory in such a way that a workman or an employee is, by force of law and even against his own will, insured against accident on his entrance into the employ of a concern which is affected by the particular law. Whereas, finally, the insurance against sickness is carried on, as a rule, within a restricted sphere of activity by a majority of the approved societies, the insurance against accident is a matter of a single institution, the National Accident Insurance Institute of Lucerne, which does its business under the supervision of the federal government to the exclusion of any other system or insurance company, but as an autonomous organization with its sphere of activity covering the entire territory of Switzerland. Old age and survivors' insurance: In contrast with the sickness and accident insurance systems, this is a kind of insurance which in its very nature is of not so much importance in public health as in social economics. On the other hand, there is, for the time being, only the draft of a bill for a federal law before the parliament. With few exceptions all inhabitants of Switzerland, from the nineteenth till the sixty-fifth year, will be insured. The premiums are uniform and the annual amount for men is 18 francs and for women 12 francs, to which there must be added a contribution by the employer of 15 francs for each employee or worker. Old age benefits are granted, beginning with the sixty-sixth year, and also benefits for widows and orphans. For the purpose of increasing the basic amounts, the confederacy and

the cantons pay sums totaling the entire amounts paid within a year, which additional contributions will be distributed among all of the beneficiaries with the exception of the well-to-do ones. In this manner the old age benefits average 500 francs, the widows' benefit, some 375 francs and the single orphan benefit, 125 francs. This system of insurance is to be operated by the cantons under the supervision of the confederacy.

LEHMANN, HELMUTH: THE PHYSICIAN AND REFORMS OF SICKNESS INSURANCE, *Fortschr. d. Therap.* 5:305 (May 10) 1929.

The physician's question is the main problem in social sickness insurance. It must be recognized that the medical profession is entitled to a just compensation for its services. However, the authorities of the insurance company cannot decide the extent of medical aid. This is mainly decided by the physicians themselves, and the insurance physicians frequently feel that they have to please their patients and so declare the patient unable to work and in need of treatment, regardless of the effect this might have on the financial conditions of the insurance company. Accordingly, the author thinks it necessary that the decision of whether or not the patient is able to work should be taken away from the insurance physician and should be made by the social physician. The social physician, whose service is more of a judicial nature, should not be paid in the form of a fee for each individual case, and he should also fulfil other tasks, such as improving sanitary conditions and determining the social cause of the disease. In this manner the service of the sickness insurance would be changed. The insurance physician should do only what he does in private practice. His aim should be to cure a patient as quickly as possible. The social physician should not act like the former confidence physician who made his decision after the patient had received the support of the insurance company for a long period, but he should reexamine the patient at the beginning of the sick period. The author thinks that in this manner the exploitation of the insurance company by the physician or patient could be avoided. The author does not think that the number of social physicians would need to be much larger than the present number of control or confidence physicians. This new arrangement would also do away with other shortcomings. As conditions now are the sickness insurance companies cannot supply the excessive number of physicians with work, which has the effect that thousands of capable young physicians are excluded from insurance practice and are therefore practically without means of subsistence. In a few years 10,000 new physicians will expect to be admitted to insurance service, and they will certainly not stand by inactive. In order to give

every physician his chance and at the same time to preserve the social insurance companies, it is necessary that the "Planwirtschaft" be introduced and that the insurance companies and the medical profession cooperate.

LOEWY-HATTENDORF, E.: THE EMERGENCY DECREE AND EARLY COMPLICATIONS, *Med. Klin.* **26**:1729 (Nov. 14) 1930.

The author points out that the effects of the emergency decree can already be noticed. This decree ruled that the insured patients have to pay for the permission to be treated and also pay partly for their medicaments. The government wanted to counteract malingering and reduce the large number of minor cases, which really are not in need of medical attention. As a result of this, the workers' contributions for sickness insurance could be reduced. However, their contributions for unemployment insurance had to be increased. The author thinks that the emergency decrees have had a detrimental influence on the health of the population. Especially in cases of venereal diseases it has been found necessary to cancel the regulation that the insured patient should contribute for the treatment and for the medicaments. The author criticizes Liek's entirely negative stand on the question of social insurance, and advises the physicians to unite their efforts rather than to split up in groups and oppose each other.

MACDERMOT, J. H.: HEALTH INSURANCE IN BRITISH COLUMBIA, *Canad. M. A. J.* **23**:173 (Aug.) 1930.

The next session of the British Columbia legislature promises to be one of supreme interest and importance to the medical profession of Canada. There is a widespread and genuine demand on the part of a large section of the public that health insurance be put into force. The public sessions of the commission have shown this. Cities, municipalities, industrial workers, in fact labor as a whole, and women's organizations, are all agreed that health insurance is vitally necessary. The majority of employers of labor agree that in some form or other it is advisable. There can be no doubt that the community at large wants health insurance legislation. We put forward the following as principles that we believe should underlie any scheme. First, it should not involve more dislocation of our present system of medical practice than is actually necessary. Progress should be by evolution rather than by revolution. Secondly, prevention of disease is of equal importance with its treatment, and should constitute a main part of any scheme. But the preventive and therapeutic sides should

be, as it were, in separate compartments. The two will be linked by the administration, but should never be mixed. Thirdly, the scheme should involve complete medical service, and the charge made to those who are responsible for finding the money should be adequate to cover this. In the course of the inquiry, the question arose how widely should a health insurance be applicable to the population. Who should be eligible to benefit by it? When we were asked as a profession, what we thought, our answer was, that we felt that since this was experimental legislation, it might well be applied at first to a limited group, namely the group that needed help most, that is, the poorly paid workers, with incomes of \$1,500 or less. Later, as the experiment proved successful, the wage limit could be raised to include larger groups. The British Columbia Hospital Association supported and endorsed the idea of health insurance, and its spokesman advocated its general application, regardless of salary. As regards maternity benefits, we expressed ourselves as disagreeing with the principle of cash bonuses, and as thinking, rather, that provision should be made for better prenatal and postnatal care, with a view to reducing maternal and infant mortality. Two questions present themselves for answer, and an answer must be found. How can we guard against abuse, first by the beneficiary, who may, it is thought, demand treatment unnecessary or for an unduly long period, or may endeavor to obtain more than his share? He has paid his dues, and will feel entitled to treatment whenever he wants it. Such abuse would, of course, greatly increase the cost. It has been suggested that the beneficiary should be made to pay part of his hospital dues, even part of his medical fees. We do not like this idea, as the result would in many cases be that these portions of the fee would not be paid and, in any case, this brings us back to an unfair distribution of cost. The other question is, will some doctors abuse their privileges under the act? Will there be padding of accounts, or unnecessary charges? We do not think that there is any danger of this with the great majority of medical men, but there may be some who will not play quite fair, especially if the method of payment of doctors is the one we ask for, namely, by schedule of fees for work done. Here we feel that, as a profession, we should offer our help to prevent any abuse by every means in our power. Should the act be limited at first, either in regard to those eligible for benefits, or as to privileges granted to the beneficiary? We incline to the first mentioned type of limitation. If the experimental stage of this legislation is to be of the fullest value, the conditions under which it is carried out should be as nearly as possible those which it is hoped later to reach, and it would be better, we think, to start with a somewhat smaller group, and apply an ideal act to this, than to limit the extent of the service given. In the latter case, the conclusions drawn might be incomplete and inaccurate. The next fundamental principle is the use of the family doctor or general practitioner as the

backbone of any scheme. Not that the scheme neglects the specialist. On the contrary, it puts him in the forefront of the plan. Used properly, he is essential to the success of the scheme, and the use of him constitutes the third basic principle, which covers also all auxiliary services, as to the relation of the family doctor to the hospital. We believe that where the freest possible access to the hospital is available to every doctor in the community many advantages are gained. The average doctor does better work, and the public has to depend on the average doctor. Undoubtedly, regulation and supervision are advisable and necessary, and possibly to a degree which we may rather dislike, but this does not detract from the thesis set down above.

MCCULLOUGH, J. W. S.: SICKNESS INSURANCE, *Canad. M. A. J.* 21:168 (Aug. 21) 1929.

A state system of health or sickness insurance including an improved public health service is desirable. Such a service would afford: a sense of security in time of sickness on the part of the entire insured population; medical attention to those not now in a position to obtain such attention; early recognition and treatment of minor ailments, and the possible prevention of incurable conditions; a clinical record of a large portion of the population; a feeling of greater financial security among physicians who serve the industrial population; a certain assured income; participation in and remuneration for certain public health services; the spread of health education among the people; early discovery of children's defects through medical inspection of schools.

MÖRING, G.: INDEPENDENT PHYSICIAN AND INSURANCE PHYSICIAN, *München. med. Wchnschr.* 76:158 (Jan. 25) 1929.

Möring objects to Liek's article. He stresses that the difference between an independent physician and an insurance physician is not as Liek likes to make it appear; namely, that an insurance physician cannot be, or generally is not, a good physician. He also objects that Liek shows only the disadvantages of the insurance system and forgets that it has also many advantages, and because of this his conclusions are based on wrong suppositions. The supervision to which Liek objects so emphatically is really not as irksome as he makes it appear. The author, who has had ten years' experience as an insurance physician and who is not at all indifferent to supervision, has never found it irksome. He also shows that one can keep the expenses for prescriptions at a minimum without injuring the

patient, and that in private practice the physician is likewise obliged to consider the monetary condition of his patients. In regard to malingering patients, Möring points out that in 90 per cent of the cases the experienced physician will detect it. The examples cited by Liek, of physicians who exploit the insurance for their own gain, the author considers too far fetched and really no objection to the insurance system. Such physicians are simply not fit to belong to the medical profession either as private practitioners or as insurance physicians. Moreover, no one can deny that in private practice it likewise happens that physicians exploit their patients financially. Why charge against the insurance system what are really generalized human shortcomings? the private patient quite frequently has the feeling that he is treated not only on account of his ailment but also because the physician has to make a living. An insured patient cannot make this charge, especially in those cases in which payment is made in lump sums. It should not be overlooked that private practice also has certain disadvantages. In the case of private patients the physician is often annoyed by patients who run to quacks, which is almost never the case in insurance patients. The physician has many difficulties in collecting his bills, whereas the insurance physician is entirely free from these worries. Insurance is perhaps superfluous if the worker earns enough to save something in order to be able to pay doctor's bills. However, a large percentage, about 85 per cent of workers, is paid such a minimum wage that it is impossible to save for such emergencies, and in the absence of insurances the physician would receive nothing for his services. It is impossible to say "every assistance for the weak" and then add "but no insurance." Today effective aid is possible only by insurance. Charity is certainly still more demoralizing than insurance. A comparison with American conditions, where, as Liek points out, social insurance does not exist, is not possible because the economic conditions of the American workers are much more favorable than those of the German workers. To judge social insurance either as a blessing or as a curse is, like most unipolar assertions, one-sided and wrong. It should be admitted that insurance, like most human institutions, has its advantages and its disadvantages. It is the duty of physicians to point out and help to improve the shortcomings, but to condemn social insurance as a whole is not right.

MUSGRAVE, W. E.: IS UNIVERSAL LIFE INSURANCE COMING?
J. A. M. A. 86:1644 (May 22) 1926.

Some 55 million individuals, or approximately one-half the people of the United States, are protected by life insurance. Supervision of the health of policyholders, which is being expanded to offset the increased hazards inherent in lowering

the standards for acceptable risks, is a movement of transcendent importance to all people and particularly to physicians and other health-conserving agencies. Any practical movement that will insure better health by improved medical care and thus prolong life and promote happiness, regardless of its possible effects on physicians and other existing health agencies, ought to be encouraged. But before steps are taken calculated to change radically the age-old custom that recognizes health as a personal matter served by personally selected advisers to a more public matter to be attended to by the agents of some corporation, all the logical consequences ought to be reviewed. The road of social progress is strewn with the wrecks of schemes having for their ostensible purpose the commendable one of promoting health and longevity by the introduction of some wholesale organized system of medical care. One of the largest and oldest of these movements has for its purpose the control of health by the state, to be supported by taxes and served by government employees "free" alike to all citizens. In several countries this scheme has developed into a government monopoly, compulsory for the majority of the citizens. These "compulsory health insurance" or "state medicine" movements, as they are called, vary considerably in methods, but in all the objective is the laudable one of promoting health, treating the sick and prolonging life. They all propose to do this by substituting, for the traditional personal health care by health advisers selected by the patient, wholesale practice carried on by government departments. Direct and open efforts to governmentalize health and medical service have always been defeated in the United States, but the leaders of this brand of socialism and commercialism have succeeded in projecting their tentacles far into the social structure in a score or more directions by governmentalizing health service for this and that group of citizens. The most promising antidote in sight to the progressing movement calculated to governmentalize, socialize, sovietize health is the rising tide of associations, societies, groups and corporations that propose to distribute the costs and character of health service on some basis of voluntary agreement between the beneficiary, the health-serving agency and the responsible organization. There are history-making possibilities inherent in this situation, but that they are being intelligently grasped remains to be seen. The idea needs leadership of a kind that will protect the interests of the beneficiary, the health agencies who serve and the investors, and which will do these things in a manner calculated to create and sustain public approval. The great insurance companies are in a position to do this more than ever now that the life companies are enlarging their field to include much of what was formerly considered to be health and accident insurance and personal health service by personally selected physicians. The future consequences of this expanded and expanding type of life, health

and accident insurance on existing agencies of health is problematic; but if the future practice of medicine and health service is to be by employees of insurance corporations, as the only alternative to bureaucratic government service, the interests of society, as well as those who serve, lies with private business.

NATHAN, P.: THE SICKNESS INSURANCE PROBLEM IN FRANCE, *Deutsche med. Wchnschr.* 55:1385 (Aug. 16) 1929.

In France, sickness insurance does not exist. Only in the territory belonging to Germany before the war has the existing insurance been continued, and since the physicians are paid for each service rendered and not in lump sums, most of them are satisfied with the existing conditions. The French social democratic party demanded the introduction of sickness insurance. Especially the farmers objected to the new law on the ground that they could not afford to contribute more, and also that the existing sickness benefit organizations, namely, the treatment in the hospital and the law regarding occupational diseases and accidents, gave adequate protection. The majority of industrial employers and numerous physicians have taken the same stand. They are of the opinion that the advantages of sickness insurance are small compared to the many shortcomings. They are afraid that insured persons would seek medical aid for minor complaints and would be inclined to exploit the insurance organizations. Thus the labor shortage in France might become still more marked and the production capacity of the country might become impaired. The author points out that although France has many hospitals that are supported by public funds and by the state, these facilities are not sufficient to give the workers who are sick, the care which they can rightfully demand. Most French hospitals are old, dating back to the sixteenth, seventeenth and eighteenth centuries. They are not up to the standard of modern hygiene, and the food the patients receive is not as good as that in most German hospitals. Only few hospitals have a better equipment. Hospital physicians receive, as a rule, ridiculously low salaries. The law of 1898, according to which the employer is liable for accidents which the employee sustains during working hours, and which in case of total disability compels the employer to pay the worker one half of his usual wages, protects many workers and is a sort of limited accident insurance. However, it does not give protection to workers who become ill outside of working hours. Private insurance organizations as they exist in Germany are not known in France. The author thinks that if conditions in France are carefully surveyed one cannot deny that there is need of a general sickness insurance. The strongest opposition against enforced sickness insurance comes from the medical profession. The organizations of physicians

declare that they are willing to lend their cooperation to the new law only if the medical profession retains its former independence and if their fees are not reduced below those customary in private practice. The author doubts that all the demands of the physicians can be considered.

NOTHMANN, H., and SCHMOLLER, H.: SOCIAL INSURANCE AND THE FAMILY, *Deutsche med. Wchnschr.* 56:837 (May 16) 1930.

Many years of experience in family welfare work as physicians in an infants' and children's welfare station has convinced the authors that family sickness insurance is necessary. In regard to the persons who should be protected by this insurance the authors state that the wives and children of the workers, as well as widows and orphans should be protected. The payment of the sick benefit money should begin on the first day, because if it was necessary to let the usual three days elapse, many families would be in want. Children of insured workers should be entitled to hospital care, because under the present unfavorable housing conditions this is absolutely necessary. The authors do not approve the regulation that in case of illness of a member of the family the insurance will pay only half of the expenses for medicaments. By this rule many of the benefits of family sickness insurance are made void again, and the result is that in many cases medical aid is asked too late, for, as the authors point out, in diseases of infants, early treatment is usually of vital importance. The members of the family of the insured should be entitled to the same care as the insured person himself.

PRYLL, W.: CARE FOR HEALTH OF INSURED POPULATION, *Klin. Wchnschr.* 8:1678 (Sept. 3) 1929.

Pryll discusses the decree of the federal government of Feb. 27, 1929, regarding the care for the health of the insured population. He thinks that this decree may be the beginning of a new epoch in social hygiene and in social insurance. The decree rules that in order to improve the health conditions of the insured population, which now includes about two thirds of the German people, the various insurances, the various bodies for welfare work, official or private, the state and municipal sanitary organizations and the physicians should cooperate. This cooperation between the various organizations will, in some cases, prevent double service being given, and thus means will become available for rendering aid where it is needed. In this manner the care for the health of the insured population

becomes simpler and more economical. The care for the health in the meaning of the decree includes general measures and measures in special cases. Its main object is the combat of diseases that endanger the health of the people such as tuberculosis and venereal diseases, and the improvement of the health of the population.

REICHERT: RELATION BETWEEN SOCIAL INSURANCE AND MEDICAL SCIENCE, *Deutsche med. Wchnschr.* 54:1048 (June 22) 1928.

Health welfare ought not to be confounded with social insurance. The purposes of social insurance are to restore the working capacity impaired by a disease, to stabilize the economic situation of the insured by relieving his income from expenses in connection with sickness, and to compensate for loss of the whole or of a part of his working capacity as a result of accident, chronic disease, old age or death. The main purpose of social insurance is to insure the workman's production and consumption value in case of loss of his working capacity. The organization of social insurance is a combination of a competent self government with control by the federal government. Social insurance means insurance of the production value to the employer; it means insurance of wages to the employee. The sickness funds, the cooperative associations and the provincial insurance institutes were unanimous in their statements that general practitioners as well as physicians connected with hospitals or with university clinics often do not understand the requirements of social institutions. Reichert regards the fact as a "crisis of the medical profession." The "crisis" developed in the last decades. The modern physician must know social insurance legislation, the social needs of the population, the economic conditions of the country and the social philosophy. The latter is chiefly composed of social hygiene and social psychology. The social education of a physician must include study of the psychology of healthy persons and of patients; the psychology of persons of various ages and of different social ranks. He must be familiar with the social work culture. Study of the judicial features of social insurance, from the federal insurance laws and from police-sanitary legislation is necessary. Thus he will learn, for instance, that the working or the earning incapacity should be determined with regard to the sickness insurance, the accident and the invalidity insurances and the professional insurance. The laws on adjustment, and on unemployment insurance, and on federal insurance, should be studied. Medical science must advance to the requirements of modern social life.

RINK, W.: REVIEW OF OPINIONS ON RELATIONS BETWEEN PHYSICIANS AND SICKNESS FUNDS, *Deutsche med. Wchnschr.* 56:896 (May 23) 1930.

In Heinemann's opinion, the sickness funds have the right, in case of need, to employ more physicians as allowed by the accepted proportion. The safeguarding of physicians' interests does not interfere with the self government of the sickness funds. Limitation of the number of physicians employed in the sickness funds, Kippenberg says, is a necessary measure for the economic and ethical welfare of the medical profession. The sickness funds are entitled to supervise medical aid with regard to its efficiency. The physicians are responsible for the allowance of sickness payments, medicines and curative remedies. The average income of a sickness fund physician amounts to 13,000 marks a year, while the income of a private physician amounts to 20,000 marks a year. An adequate distribution of medical help among the population is a requirement of medical ethics. In order to prevent unnecessary calls on the sickness fund physicians, the insured ought to refund a part of the expenditure for medical fees and medicine. The share may amount, as in French social insurance, to from 15 to 20 per cent. Oberwinster reports the expenditure for medical treatment given to the insured. In 1928, the expenditure for medical treatment of the insured patients amounted to 276 million marks and that for treatment of members of the family to 109 million marks. In 1930, the expenditure for medical treatment of the insured patients may reach about half a billion marks. The total income of the insured population amounts to about 30 billion marks; hence the average share of an insured member in the expenditure for medical help amounts to about 1.7 per cent of his income. The expenditure for medical care of the noninsured population amounts to from 1.4 to 1.5 per cent of its income. It appears that the total income of the 36,000 German physicians from the income in the sickness funds and from private practice amounts to one billion marks. Thus the average income of every physician appears to amount to almost 30,000 marks. Okrass reminds that when a sickness fund is closed its contract with the physician is considered broken three months after notice has been given or even at the day of closing. In case of an opening in another sickness fund, preference is given to the formerly employed physician. In case of merger of sickness funds, the physicians of the closed funds may become employed or obtain compensation from the consolidated sickness fund. In case of disincorporation of a professional or of a trade sickness fund the involved physicians could not present any claim so far. Nevertheless they were given preference in case of a vacancy.

ROBERTS, H.: THE POINT OF VIEW OF A PANEL DOCTOR, *Lancet* 1:111 (Jan. 11) 1930.

According to Roberts, since the middle of the last century, when parish physicians were appointed in every district to provide domiciliary treatment under the poor-law for those unable to make any medical provision for themselves, there has been in England a steadily increasing recognition of the desirability—on public, philanthropic, and prudential grounds—of arranging for some sort of medical supervision and treatment in times of stress. Parish doctoring was, for the most part, not such as to lead those not so compelled to trust themselves to its ministrations. Throughout the country a system of voluntary clubs grew up, the members of which, by paying a few pence a week, were guaranteed, in addition to sundry money payments during illness or old age, the services of a physician when necessary. The club physicians received but a small annual payment in respect of each member—generally about four shillings, out of which drugs had to be provided—and, although many gave a service fully up to the standard represented by contemporary medical knowledge, the system put too great a strain on professional and technical honor. Club doctoring came to be looked on as but one shade better than parish doctoring, and accordingly the political ground at the end of the first decade of this century seemed ready for some big national scheme of domiciliary treatment—a readiness which Mr. Lloyd George and other astute, public-spirited or philanthropic politicians sought to exploit. Thus it was that, in 1912, the Health Insurance Act came into operation and every wage-earner in the country was provided with a panel doctor of his own. Unfortunately, the methods of politics, rather than those of science or of statesmanship, were the ones employed in bringing about this medical revolution. The one piece of medical organization that emerged is the panel system; the working of which has at least been an interesting experiment in democratic methods. Considered in the large, the panel service represents a great advance on any collectively provided medical service that preceded it. Moreover, anyone familiar with the conditions of private medical practice among the city poor at the beginning of the present century can but recognize the immensity of the improvement that has taken place. The physician—so far as insured persons are concerned—is spared the humiliating experience of taking from an ill nourished family a fee which represents tomorrow's dinner; nor need he apologize for visiting his pneumonia patient as often as he thinks it desirable.

ROWAN, A. A.: A COMPREHENSIVE STATE SICKNESS INSURANCE ACT, *Canad. M. A. J.* 22:831 (June) 1930.

Rowan thus enumerates the benefits that a comprehensive law for sickness insurance would give to Canada as a whole: (1) the removal of the financial dread of illness; (2) the early

diagnosis and adequate treatment of the majority of ailments; (3) the greatly increased equality or fairness of distribution of the cost of sickness; (4) the general improvement in community health resulting therefrom; (5) the statistical data so obtained of use not only to the medical fraternity and through it to the people, but the particular and immediate value in demonstrating to all the crying need of better housing and stricter public health regulations, particularly in certain cities and districts; (6) the immediate shattering of the public's complaisant ostrich-like attitude in being willing to do without an adequate number of hospital, mental asylum and sanatorium beds. The benefits which would accrue to the medical profession from such a law are at least sufficient to make all physicians wish to propagate a demand for comprehensive state sickness insurance legislation among the people of Canada. The knowledge that every time he is called on a case he is sure to receive at least two thirds of his fee at the end of the month; that eventually he will be able to secure a hospital bed for every patient who requires it, whether for treatment or diagnosis; that he may hope to be relieved, and be able to attend postgraduate lectures and outstanding conventions every few years; that a certain monthly premium entitles him or any of his dependents to prolonged hospitalization if necessary; all these things should, so it seems to the author, urge any physician to propagate the simple idea of equalizing the cost of sickness by dividing it among the number of people in the country.

RUBINOW, I. M.: DO WE NEED COMPULSORY PUBLIC HEALTH INSURANCE? YES, *Annals of the American Academy of Political and Social Science*, November 1933, pp. 112-120.

The primary purpose of health insurance must be restitution of the material loss caused by illness. Health improvement is not the fundamental purpose of health insurance. The money benefit must be sufficiently low so that there will be an incentive left to long for recovery. The determination of the duration of the benefit requires a distinction between illness and chronic invalidity with different organizations to administer the benefits. The maternity benefit has proved to be an essential feature of most sickness insurance systems. The funeral benefit is largely a matter of historical precedent. A health insurance system should also endeavor to compensate for the necessary cost of medical care in the broadest meaning of the term. Historical influences have established the tradition of rendering medical aid not in money but in kind. Benefits in kind are cheaper because they are bought and paid for in wholesale. The forms of service should be compulsory and include all medical care. This, however, is a counsel of perfection. Few systems approach it completely, and for an obvious reason—its cost. Early and ample medical aid is justified even from a narrow insurance

point of view. Benefits should also be extended to dependents. An effective health insurance system is a living, growing thing. While in the beginning certain minimum requirements were established, there is a tendency constantly to extend these.

SAND, R.: SOCIAL INSURANCE, *Colorado Med.* 27:120 (April) 1930.

Sand asserts that the idea of sharing together common risks is as old as mankind. The family, the tribe, the neighborhood, the community have always practiced some kind of mutual help. Insurance is nothing else than the reduction of this vague, unorganized and unequal form of assistance to an exact scheme, in which every one knows precisely to what sum his payments or his eventual benefits will amount. The oldest example of organized insurance is said to be the contract by which many years before Christ, the ship owners of the Greek islands undertook to make good by common payments the losses sustained by any of them. In ancient Greece and Rome, as well as in the Middle Ages, the artisans formed mutual benefit societies which took care of the widows, the orphans, the aged, the sick. Life insurance, fire insurance and those many forms of insurance that are now in force developed later on business lines. Social insurance was, perhaps, not so greatly called for when people lived mainly by agriculture. If the farmer is sick or if he dies, the wife, the children, the relatives, the neighbors will keep things more or less going. And there is no unemployment on the land. With modern urbanization and industrialization, the situation is different: the worker can get through provided his health is good and he can find work. But the cloud of a fourfold menace hangs constantly over his life: accident, sickness, old age and, within certain limits, unemployment are insurable risks. Their occurrence, at a given place and time, is fairly regular. The proposal to provide for these risks through a general contributory scheme, instead of leaving their victims to be ministered to by public or private charity, originated around the year 1848, when social problems came very much to the fore. The first nation which was bold enough to put this scheme into practice was the German empire. The government began with accident insurance and gradually took up sickness, invalidity and old age. Great Britain, under Mr. Lloyd George, adopted this system and added unemployment insurance. Presently some form of compulsory accident, sickness and invalidity insurance came to exist in every nation of Europe (except Albania, various Swiss cantons and Spain, which, however, is about to introduce maternity insurance). In France and in Belgium, laws introducing compulsory sickness insurance are in the process of adoption by parliament. Outside of Europe, it has conquered Japan, Chili, Argentina and Uruguay; Australia, Brazil and

South Africa are getting into line. Denmark, Finland, the Netherlands and Sweden have not introduced compulsion, at any rate for sickness insurance; the state, however, subsidizes voluntary insurance to such an extent that it has become practically general. No state, after having adopted social insurance, has ever thought of abolishing it. On the contrary, people after a certain time fail to understand how they have been able to manage things without social insurance.

SCHOLZ, E.: REORGANIZATION OF SOCIAL INSURANCE IN GERMANY, *Deutsche med. Wchnschr.* 51:1242 (July 24) 1925.

Scholz discusses the four types of social insurance: namely, sickness funds, provincial insurance institutes, cooperative associations and compensation funds. Their organization presents an extensive self government. He reviews the resolutions of the board of directors and of the committees, and their activities with especial regard to the welfare functioning; also the activities of the board of supervisors and the legislation. Two facts are pointed out: the connection between the insurer's welfare and the economic situation of the country, and the considerable responsibility of officials of social institutions. Statements referring to the reorganization of social insurance are classified in three groups. According to the radical group, social insurance societies should form a union with a self-government composed of workmen. The union should control hospitals, sanatoriums, water resorts, health centers and the activity of physicians and their help. Financial means can be obtained by confiscation of properties and by confiscatory taxation of large incomes. Such radical measures have little hope for achievement as long as the communistic party is powerless. The second group includes suggestions of the committee of supervisors and those made by Stier and Somlo. The former advises that district and provincial sickness institutions should be founded. The management might be of bureaucratic nature and be provided with a limited self government. Stier and Somlo suggested that the welfare and medical care be centralized in a large district sickness fund. Pension payments can be covered by special dues from employers, government and communes. The suggestions are supported by the social democratic party. Suggestions of the third group are chiefly concerned with enforcement of the compensation sickness funds. The suggestions originated in the merchants' sickness compensation funds and are supported by the bourgeois parties of the Reichstag. Until 1923, there was no close relation between the medical association and the social insurance. Then the inflation danger brought about cooperation between the sickness funds and the medical societies. At the same time, arbitration bureaus and a federal arbitration bureau were organized; hence conflicts between physicians and the sickness funds could be

eliminated in a legislative way. The conflicts are due not to economic causes but to an insufficient participation of physicians in the social insurance organization. The expected reorganization of social insurance gives the medical profession the opportunity to cooperate in the activities of the social insurance institution.

SEIFFERT, G.: SICKNESS INSURANCE IN BAVARIA, München. med. Wchnschr. 77:410 (March 7) 1930.

Seiffert gives a statistical report on sickness insurance organizations in Bavaria during the year 1928. The total number of members of these organizations was 2,042,683. Of these 1,590,670 belonged to municipal and the others to industrial and other insurance organizations. The members pay about 7.5 per cent of their wages and in some insurances from 5.5 to 6 per cent. Most insurance organizations pay sick benefit for twenty-six weeks, some up to one year. In nearly 50 per cent, the sick benefit does not exceed 50 per cent of the wages. Others pay 75 per cent. Generally the benefit payments start on the fourth day, but in some organizations on the first day. Most sickness insurance organizations pay a certain amount for the support of the dependents, and many now have family insurance. Since 1926 they have contributed also to the expenses in confinement cases.

STIER-SOMLO: CRITICISM OF CRITICISM OF SOCIAL INSURANCE, Deutsche med. Wchnschr. 54:1304 (Aug. 3) 1928.

Stier-Somlo discusses a book published by Liek on "Die Schäden der sozialen Versicherungen und Wege der Besserung" (Shortcomings of the Social Insurance System and How to Improve Them). A study of this publication and of Liek's other work, "Der Arzt und seine Sendung" (The Physician and His Mission), gave Stier-Somlo the impression that Liek is a man whose frankness, fearlessness and good intentions deserve highest praise. Such books have to be written because such a wide field as that of social insurance cannot be completely covered in an article prepared for publication in a periodical. The book gives a clear survey, and the numerous consenting as well as opposing criticisms are a proof that the work discusses problems that are of vital importance. However, Stier-Somlo does not entirely approve the manner in which Liek approaches his subject. He thinks that many of the examples Liek cites lack the evidence of general conclusiveness. It is true that Liek also shows some advantages of the sickness insurance; but he detracts from these advantages

by generalization of the disadvantages. This is shown especially in the chapter on exploitation of sickness insurance by economically weak persons, who simulate disease in order to make their living by means of the sickness insurance. Stier-Somlo thinks that such misuse of the sickness insurance can be overcome by a more strict control. He also objects to Liek's making it appear as if the favorable hygienic conditions in Germany are not largely due to the sickness insurances. Liek goes too far when he asserts that sickness insurance undermines manliness, and fosters physical and psychic weakness. To the expectation that the unemployment insurance would do away with an exploitation of the sickness insurance Liek replies that this would not alter the condition but that it would only have the result that the misuse is shifted to the unemployment insurance. This is a misunderstanding, for unemployment insurance exists for persons who are able and willing to work but who, without their fault, find themselves out of employment. Liek's charge that the administration expenses of sickness insurance are excessive is likewise not justified, for it has been proved that the administration expenses do not exceed 6 per cent. That medical aid and medicaments when furnished by an insurance will lead to careless squandering is untrue, and if in this respect there really exist shortcomings, then, one should ask whether the physicians are not partly at fault. A further thesis of Liek is that accident insurance demoralizes. Stier-Somlo admits that exploitation and compensation hysteria cannot be entirely prevented, but one should not overlook entirely the good effects of this branch of social insurance, which enables the worker to regain his health and the ability to become again self supporting. Liek admits that it is impossible to abolish the social insurance system entirely but he advocates a deep-going reform. But in contradiction to this reform plan he then states that our aim should be to make the insurance organizations superfluous, to make out of the millions of insured persons again free citizens, who in sickness, accident and old age can take care of themselves. The free citizen should be able to consult the independent physician without interference from insurance organizations. No one will deny that this is a desirable state; but that such expectations are grotesquely optimistic, at least for the conditions in Germany, can likewise not be denied. Among the reform propositions Liek advocates that the insurance physician should become a government employee. Thus the physician would not be interested in disease, but rather in health. The physician would find sufficient time for relaxation and for further studies, and the keen competition among physicians would cease. To such plans Stier-Somlo replies that he has always had the belief that the physician is not interested in the disease of the patient but rather in his health. He admits that the problems of the personal and economic security of the physician are important.

However, that for these utilitarian reasons the physician should sacrifice the freedom of his profession goes a little too far. It is true that the overburdened insurance physician finds little time for further study, however, the new problems he encounters daily compel him to it, and it is to be questioned whether the physician who is in government employ will always devote his leisure time to further study. Besides this plan of making a government employee out of the insurance physician, Liek's reform proposals are nil. But in spite of all the shortcomings the publication of this book has been an advantage, because it has forced the medical profession to think and to face facts.

STRAUSS, PAUL: BENEFITS TO PUBLIC HEALTH OF SOCIAL INSURANCE, Bull. Acad. de méd. 102:507 (Dec. 3) 1929.

Strauss maintains that the medical body of Germany is as a whole heartily in favor of the system of social insurance as it has affected public health. Social insurance has enabled the people to have far more efficient treatment than they could formerly afford. It has been of valuable assistance in promoting sanitary measures, social hygiene, and campaigns against infectious diseases, especially tuberculosis. It has made possible the early examination and diagnosis of a far greater proportion of patients, and has moreover extended its surveillance to patients throughout convalescence. So far as social insurance affects the health of the people, which is the chief concern of every earnest physician, the system is of indisputable value. The author quotes statements to this effect from several prominent members of the German medical body. He says that the criticisms of the workings of the system are merely those of detail and that the recent attacks made by a few authors have a purely individual character and represent only detached and isolated opinions.

STRAUSS, PAUL: THE SOCIAL INSURANCE SYSTEM, Bull. Acad. de méd. 102:661 (Dec. 17) 1929.

Strauss repeats his assertions as to the benefits produced by the social insurance system in Germany and those to be produced in France, upholding his convictions with additional statistics. In his opinion, while individual and familial medicine still deserves much loyalty, the new field is that of social medicine and hygiene. It is only through socialized efforts in all phases of national life that the problems created by the World War may be solved. The academy should realize this and endeavor to give the best services of the medical profession to the social insurance system.

SYDENSTRICKER, EDGAR: GROUP MEDICINE OR HEALTH INSURANCE, WHICH COMES FIRST? American Labor Legislation Review, June 1934, pp. 79-86.

The type of health insurance that is adopted in the United States should observe the following considerations:

1. Quality in medical care should not be sacrificed to economy in costs. Free choice of physician and other means to this end are assumed to be essential.

2. Group payment should be planned for a large population and preferably on a state-wide basis because of the need for actuarial stability and for administrative coordination with existing public health and public welfare facilities.

3. The plan should be compulsory.

4. The insurance for, and the provision of, medical care should be divorced from cash benefits for wage loss or other purposes (except perhaps to remunerate employed women for wage loss preceding and following confinement and except for low income families when the lack of even small cash resources interferes with the effectiveness of medical care).

5. The plan should not include proprietary or profit-making agencies.

6. There should be no independent intermediary between the potential patient and the medical agencies.

7. Administrative procedures should be determined by the joint action of professional and lay groups, and the plan should provide for the professional administration of professional personnel and activities.

8. The plan should provide for diverse arrangements in the provision of medical care, depending on local conditions in respect to availability of facilities and ability to pay for medical care, except (a) that the care provided should, so far as possible, cover complete home, office and hospital service including necessary health examinations, (b) that economy should be assured by proper organization of the practitioners and agencies furnishing service, and (c) that the quality of the service rendered should be insured, so far as it can be insured, by the joint professional responsibility of the groups of practitioners rendering the service.

9. The plan should provide for maximum integration of the medical provisions with public health and other governmental authorities engaged in medical activities.

WINSLOW, C.-E. A.: SICKNESS INSURANCE IN CENTRAL EUROPE AND ITS LESSONS FOR US IN THE UNITED STATES, Yale J. Biol. & Med. 1:391 (July) 1929.

Winslow traces the history of the spread of sickness insurance in Central Europe thus: It has been compulsory since 1883 in Germany, since 1888 in Austria and since 1891 in Hungary. Between 1900 and 1913, the compulsory insurance was accepted

by Great Britain, Luxemburg, Norway, Rumania, Russia and Serbia. Since the Great War, Bulgaria, Czechoslovakia, Greece, Jugoslavia, Poland and Portugal have been added to the list. A comprehensive social insurance law goes into force in France next January, and Holland will follow suit a little later. Denmark and Switzerland have highly developed voluntary systems but have not adopted the principle of compulsion. The spread of a sickness insurance program to every important country of Europe except Italy, Spain and Sweden is evidence of the practical value of such a system of providing for the emergencies of illness; and, from a theoretical standpoint, the plan is vigorously defended as providing the worker with relief in time of need which he can accept as a right, and not as a charity, because he has already paid his share toward it. On the other hand, the compulsory feature of such legislation suggests to the American mind a paternalistic regulation of the welfare of a working class set apart from the rest of the community—a concept which Americans are somewhat slow to accept. Perhaps when a serious consideration is given to social insurance in this country, something like the program of Denmark may suffice without the sacrifice of personal liberty involved in a compulsory program. On the whole, and in spite of difficulties and drawbacks, there can be no reasonable doubt that the sickness insurance systems of Central Europe have vastly improved the medical care of the industrial worker, both by providing money to pay for ordinary medical service and by developing essential institutions in the form of hospitals and outpatient services. The consultation clinics at which physicians of the funds can obtain laboratory and consultation service and special treatments for their patients represent contributions to community medical organization. The fund for the office and commercial (nonmanual) workers of Vienna maintains an obstetric and gynecologic hospital and clinic which could scarcely be equalled in the United States, and the Cecilienhaus for women's diseases at Berlin is another admirable institution of similar type.

WINSLOW, C.-E. A.: SOME REFLECTIONS ON SICKNESS INSURANCE IN GERMANY AND AUSTRIA, *New England J. Med.* 200:1161 (May 30) 1929.

Winslow states that under sickness insurance in Germany, free choice in the selection of a physician is the general rule, though in the larger cities the insurance funds maintain diagnostic clinics and treatment centers in which salaried physicians furnish consultation service, and in which laboratory tests and facilities for physical therapy are provided. In general, the relation between the funds and the physicians are strained, particularly in these urban districts. In Berlin, open war broke

out in December, 1923. The medical association refused the terms offered by the insurance fund, and the fund proceeded to open its own polyclinics staffed by its own full time salaried physicians. By March, 1924, thirty-three of these polyclinics were in operation. In 1927, 737,303 persons were treated by the salaried staff of the insurance fund clinics, 1,799,612 visits being made to the clinics and 297,815 visits to patients in their homes. The total cost of the insurance fund was about half the cost of medical care, medicine and medical supplies, under the system of treatment by private physicians. In 1927, however, the vigorous opposition of the medical profession secured an official ruling that the polyclinics of the insurance fund should no longer treat insured persons. For the past two years a reduced number of insurance fund polyclinics have been operated for the treatment of the members of the families of the insured (whose legal status is a different one from that of the insured themselves). There now exists the curious spectacle of an insured man enjoying the privilege of free choice and individual treatment by a private physician in his office while the wife and children of the insured man have the advantage of the less individualized but more scientifically organized service at an admirably equipped polyclinic. In Austria, for reasons of economy, the manual workers and the larger groups of clerical and office workers are served by salaried district physicians, while the more prosperous funds, such as those of the railway workers and the public employees, have free choice of physicians. In some of these funds the principle is carried so far that an insured person may consult even a physician who does not accept the terms offered by the fund, although in such a case the patient must of course make up the difference between the physician's charge and the fee allowed by the fund. The medical profession in Austria is perhaps on better terms with the insurance funds than is the case in Germany, partly because the salaried district physicians of the funds are allowed to do outside practice and partly because the profession as a whole in Austria is animated by a somewhat unusually high ideal of patriotic service in the crisis which this country is meeting. Sickness insurance, even under a system of free choice, of course implies that the physician is faced not by a single patient who pays him (or fails to pay him) for a single service, but by a group of patients who contract with him for so much per head or per visit. The system should not, however, be confused with what is commonly called "contract practice" in America. In England and Germany the contract is made by the insurance fund not with the individual physicians but with the medical profession of the locality or the state as a group. In spite of all such difficulties the fundamental fact remains that sickness insurance provides enormous sums of money to be used in paying for medical care, sums which would otherwise not be available. It forces the man of small means to put aside money to pay.

the physician. In Germany there are more than 20 million persons insured in the sickness funds and they pay about 16 marks (\$4) a head for medical and dental service (not including drugs and supplies). This is a fund of nearly \$80,000,000 made available for the payment of physicians and dentists, largely on the part of that section of the population which, in America, receives free medical care. Whatever differences may exist as to details, the medical profession of Germany would never for a moment consider the abolition of the system as a whole.

WOODWARK, A. S.: NATIONAL HEALTH INSURANCE AS SEEN BY A CONSULTANT PHYSICIAN, *Brit. M. J.* 1:237 (June 9, supp.) 1928.

In considering the merits and limitations of the British health insurance act scheme today, it would be well to remember what the conditions were before the passing of that much criticized and contentious measure. The average worker in the country could not afford medical advice and, consequently, many of them delayed going to a doctor or dispensary until permanent damage had been done to their health. The complete absence of income during incapacity caused the utmost anxiety, so as seriously to militate against a patient's recovery, and, indeed, his desire was to hasten back to work and to get the doctor to patch him up for the time being in order that he might do so. It is true that the village club or friendly society did, to some extent, mitigate the suffering caused by sickness to a limited number, but throughout the country as a whole the worker looked on an illness as a calamity. Major operations to patients resident in rural districts were rare, and hospital accommodation in many regions was limited to the workhouse infirmary, which has always been distasteful to the average worker, while the teeth of the poorer class generally were in a deplorable condition. Now the sick workman has an established right under the national health insurance act to medical treatment and medicines for which he makes payment, thus protecting himself from any stigma of pauperism that might attach to treatment received other than as a right. He has the approved society to show him how to obtain his benefit and to assist him in obtaining admission to a hospital or to obtain such appliances or treatment as is supplied under the additional benefit schemes. In fact, there has been a new orientation in regard to health matters for the workers of the country which the author hopes will in due course be extended to their wives and children.

SICKNESS INSURANCE—NEGATIVE

ALABASTER, G. H.: STATE INSURANCE AGAINST SICKNESS,
J. M. A. South Africa 3:612 (Nov. 9) 1929.

The Commission on Old-Age Pensions and National Insurance, in its second report, has recommended the introduction of a scheme of insurance against sickness applicable to workers in the industrial areas of South Africa. Provision is made for sickness benefit (sick pay), medical benefit (free medical attendance), and maternity and funeral benefits. The scheme which the commission has sketched in outline is for the alleged benefit of all such employees and their families as, dwelling within the insurance areas, earn not more than £400 per annum and are not engaged in agriculture. The insurance areas, termed in the report industrial areas, include areas of urban local authorities, village councils and village boards. Insurance is compulsory for those within these limits. The scheme is to be on a contributory basis, as under the panel system in England, but with higher contribution and higher sickness benefit (i. e., sick pay) for the higher wage groups. The medical benefit and the medical practitioner's remuneration is to be equal for all wage groups. There is no outstanding example of the control or prevention of any disease by a national insurance act. In England, where a considerable proportion of maternity cases come within the scope of the act, there is still an increasing death rate from puerperal sepsis. That there are certain innate evils in any government insurance scheme can hardly be disputed. It produces a tendency to lean on the state, an attitude already familiar in South Africa. There is a readiness to report sick in order to get value for money. There is a tendency to unnecessary prolongation of convalescence from trivial ailments. Every physician who has worked for a sick benefit society knows how light are the ailments from which relief from duty is expected, and surely this has something to do with "control of disease." For similar ailments the physician himself would never expect relief. Is the proposed treatment of the medical profession just? A service at "cut rates" will be a bad service. It has been said that the panel practitioners in England would not return to the old club system in England if it could be avoided. That is easy to believe, for it was worse paid and worse managed. On the other hand, it has been stated by the secretaries of the friendly societies that medical service under the insurance act has greatly improved. That, too, is easy to believe, for the work done in many cases under the club system was deplorably careless and bad. The drawback with all insurance schemes is that the patient is likely to pretend an incapacity from illness, and in cases of real illness to prolong convalescence. Sick pay produces a leisurely acquiescence in relief from duty. It is difficult for the physician to combat this spirit under a panel system. It is against his personal interest to allow the impression that he is strict, and

no doubt there are medical men who for this reason grant off-duty and sickness pay whenever it is asked for. The question ought now to be asked whether it would not be preferable to have a whole-time service, either directed by the government or organized by the medical profession, that should be responsible to the government for its satisfactory control.

AMERICAN MEDICAL ASSOCIATION: INVALIDITY, OLD AGE AND UNEMPLOYMENT INSURANCE, AND A GENERAL SUMMARY OF SOCIAL INSURANCE, A. M. A. Bull. 12:315 (May 15) 1917.

The Committee on Social Insurance of the American Medical Association has reviewed the subject of compensation against accident in the United States and abroad, showing, in a short review, the other fields of social insurance as developed in foreign countries. It discusses health insurance, German regulations, Austrian statistics, invalidity in Germany, administration of law, source of income, cost of invalidity pensions, investment of reserve fund, preventive medicine promoted, tuberculosis, old age insurance, Massachusetts commission, problems of the present and the future, old age pensions in Germany, old age pensions in Austria, old age insurance in France, normal age of retirement, death benefits, administration of old age protection, the Canadian law, Denmark, Great Britain, United States, unemployment insurance, unemployment in America, seasonal fluctuation, early attempts at solution, in Norway, in Denmark, in France, labor exchange in Germany, in England, forms of unemployment insurance, Social insurance in the United States, effect of social insurance laws, pauperism, poverty and destitution, maternity benefit, old age pensions, labor exchanges, state compensation laws compared, compensation for physician's service, voluntary welfare work, unemployment, wages and expenses, poverty and sickness, dispensaries in New York City, medical service under social insurance laws. The Committee on Social Insurance offers, therefore, to the House of Delegates the following resolutions: Whereas, The report of the Committee on Social Insurance of the American Medical Association has shown that the world-wide movement for social insurance has made such rapid progress that it has become one of the most important branches of industrial legislation in many countries, and Whereas, The growth of social insurance in this country is manifested by the wide acceptance of the principle that industrial accidents should be compensated and it is probable that this movement, as in other countries, will further demand protection of workers against the hazard of illness through sickness insurance and other social insurance legislation, and Whereas, All matters affecting sanitation and the health of the community and the

prevention of disease are the especial concern of the medical profession and affect the economic condition of the medical profession, be it therefore Resolved, That the House of Delegates of the American Medical Association in the interests of both the wage-earners and the medical profession authorize its Council on Health and Public Instruction to continue to study and to make reports on the future development of social insurance legislation and to cooperate, when possible, in the molding of these laws that the health of the community may be properly safeguarded and the interests of the medical profession protected, and be it further Resolved, That the House of Delegates instruct its Council on Health and Public Instruction to insist that such legislation shall provide for freedom of choice of physician by the insured; payment of the physician in proportion to the amount of work done; the separation of the functions of medical official supervision from the function of daily care of the sick, and adequate representation of the medical profession on the appropriate administrative bodies.

AMERICAN MEDICAL ASSOCIATION: THE PHYSICIAN OF THE FUTURE, editorial, J. A. M. A. 87:1481 (Oct. 30) 1926.

Individually, physicians are in better position than at any previous time, and there is nothing in sight to indicate a serious disturbance of mutually beneficial relationship between the adequately educated intelligent physician and his intelligent client who chooses his health adviser and cooperates with him in promoting personal and family health. It is probable that such effective and mutually helpful service will be in great demand so long as a vestige of personal liberty lasts. Ever tightening laws, rules and regulations may still further embarrass both the personal health physician and his client. State medicine—government medicine, socialized medicine—as operated through scores of channels, may continue to expand until the majority of physicians and the majority of people will become elements in some vast government machine; but even so, private individual arrangements for personal and family health service are likely to continue indefinitely to demand skilful physicians to care for the most intelligent members of society. In countries where medicine has become largely a government function, the individual who can select and compensate his own physician on a personal basis still is the envied citizen, and the physician who gives only such service is the envied one among his colleagues. The intrusions and interferences are not of physicians' choosing but are being forced increasingly on physicians and their clients by the unwarranted attempts at expansion of government into phases of personal health which violate every tradition of our people and are repugnant to those who serve and those served by a great profession. Society acting

through representative government, has responsibilities in medical and health matters as in other fields, but the line of demarcation between what is public and what is personal in matters of health must not be pushed back by government bureaus until government has invaded the privacy of the home and stands at the beside of the individual.

BAEUMER, WALDEMAR: SICKNESS INSURANCE NOW A CURSE; TRANSFORMED, A BLESSING FOR THE PEOPLE, Munich, J. F. Lehman, 1930.

Employees as well as employers who lived at the beginning of insurance have told me of the great indignation that prevailed on every pay day among the workers because of the contributions that were demanded, and also of the same resentment of the managers who had to pay one third of the contributions. Social Democrats naturally were very glad to use this heat to warm the party soup with the striking result that they had 110 representatives in the reichstag before the war, elected by more than four million voters.

It is a high tribute to the morale of our splendid people that it was not until the turn of the century that the morale of the insured broke down. When the Social Democrats became the largest party, social insurance became a *noli me tangere* to them. The krankenkassen and the cooperatives became their high schools, and no one saws off the limb on which he is sitting. A consequence is the building of expensive headquarters with wide corridors and roomy entrances. The patients who come to the physician may be divided into three classes.

1. Those who would call on the physician even if they had to pay for it themselves. I figure that these amount to about 30 per cent of all insurance patients.

2. Those who have such minor defects that, if they were paying themselves, they would come to a physician only if they were able to afford all luxuries. These make 65 per cent of all insurance patients.

3. Those who are seeking for cash benefits to which they are not entitled and who want a medical certificate. These are the ones that are commonly called malingerers. In normal times they are only about 5 per cent, but the numbers increase rapidly in times of unemployment.

If it were not for the other 70 per cent and all the other unnecessary expenses, the first 30 per cent could have almost limitless care. The combined contributions in 1925 amounted to 1,240,500,000 M (about \$600,000,000). Today these deserving patients receive only a third class care in public hospitals. Physicians with both private and insurance practice know that there are many more night calls from insured than private practice.

When colds flourish, the physician is constantly called to treat the insured, while the rest of the family with the same sickness get well without a physician. A physician friend of

mine said that he earned 34 M mileage one day making such visits. He declared that it revolted him to earn this money simply as a chauffeur when there was nothing for him to do as a physician.

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 physically to 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 *krankenassen* desire. The result was that, although his children are still at home, his wife must do homework 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.

Patients demand expensive roentgenograms, which they sometimes treat as a sort of souvenir of their sickness. An electrician broke his thumb and demanded a roentgenogram. When I explained that this was of no value in this diagnosis, he replied, "I have wished for a long time to see a roentgen apparatus in operation. I have paid enough to the *kasse*. Why should it not be done for me?"

In not more than 25 per cent of the cases in which a roentgen examination is imperatively demanded and given is it necessary. The same is true of ultraviolet ray and other radiant treatment.

The number of hospital beds has increased from 94,222 in 1904 to 471,123 in 1927 in order to accommodate the endless stream of insured who are suspected of malingering.

In the inflation year of 1923 the number of days sickness payments fell off 100,000,000 because the money paid was practically valueless. The physicians could undoubtedly chase out 65 per cent of those who come to them as sick. They could give prescriptions only in urgent cases; they could brutally send back to work all those not crippled beyond the power to work, and they could thereby receive high honor from the

krankenkassen—while they starved to death. Thirty thousand insurance physicians receive 240,000,000 M annually or an average of 8,000 M each (about \$2,000 each) with one third as many patients a physician would earn 2,665 M or 220 M a month.

Old insurance members were economical of drugs—younger members try to get their money's worth. We have now reached the situation where the insurance patient who is refused a prescription, no matter how tactfully, believes he is accused of malingering. It takes 5 per cent of the contributions for purely police purposes.

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 of such patients. 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 confidence in the physician is destroyed. I know of a man who feared to call a physician for his wife in confinement because the physician had certified the man when he was not sick and he therefore mistrusted the physician's ability and honesty.

Reports of supervising physicians have shown that cancer and other operatable diseases are not diagnosed by insurance physicians until too late, because the physician is no longer able to value the complaints of insurance patients.

The statistics of the krankenkassen naturally are not of the slightest value, since the aroused covetousness of the insured, the false diagnoses based on deception of the insurance physicians and the malingering for the purpose of gratifying the demands for cash benefits has pitched any normal demand for medical services over the house.

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

There lay, in one great hall, closely packed together, from 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.

The only way that sickness insurance can be changed into a blessing is to make it a system of compulsory saving. Such a system is outlined in detail.

The *krankenkassen* erect clinics, rest homes, sanatoriums, because they figure that it is impossible to justify the cost of medical care by individual physicians but these regimental institutions are directed by employed physicians, completely independent of the patients, and in accordance with the old Prussian militarism. Instead of being designated as clinics, every such institution should have written above the door "Police Headquarters." Just as soon as an insured person pays out only his own money, the police are superfluous and with them the "police headquarters."

BLUM, E.: HEALTH CONSCIOUSNESS AND SOCIAL INSURANCE, *Schweiz. Ztschr. f. Hyg.* 11:733 (July-Aug.) 1931.

Every sickness creates a break in the mental life. It is a threat to the body, often to life and to mental health. The sick constantly break away from the reality that has treated them so unjustly and turn their interest more and more on their own personality. This condition of self love and indulgence is accepted and built up as an equivalent to the injustice of his suffering. So one arrives at the remarkable fact that the sick seek to gain pleasure and profit from their sickness and in spite of their sufferings do not really wish to get well. So there is created out of this latent situation of conflict a wholly characteristic reaction to the very 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 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 for the repayment of a debt. This finds full and complete expression in the sick person. It has already been 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 one arrives at the tragic fact that an institution created in response to the highest social impulses and to serve social purposes encourages the antisocial attitude (asocialität) of the sick, undermines the desire for recovery and endangers health. Insurance from this point of view is a weapon that cuts in two directions.

The sufferer from a covetous neurosis is *sick*, not subnormal (minderwertig) and his covetous demands may and can arise from unconscious motives that do not deserve moral condemnation. It is just countries with the most extensive insurance systems that are threatened with strangulation by these very social institutions that have created in wide circles of the population such a lowering of the health morale that one almost wishes that these great social institutions had never seen the light of day. Up to the present time the struggle against the epidemic of covetous neuroses seems to be in vain.

DAVIES, WALTER: PRESIDENTIAL ADDRESS ON A COMING-OF-AGE: PROMISE AND PERFORMANCE, *Journal of the Royal Sanitary Institute*, October 1933, p. 219.

The sponsors of health insurance were full of promises at its birth. I think the time is now opportune to reflect a little on those promises. The act was intended to create a wide public interest in national health and the welfare of the workers, and to stimulate the interest of the beneficiaries themselves in their own welfare in the event of sickness or unemployment. As a result of the Poor Law Commission of enquiry into the health and well being of the industrial classes, attention had been focused on the utter inadequacy of the means then existing to deal with sickness among this great part of the community. The National Insurance Act at the time of its inception was believed to be one of the greatest of the measures of social legislation ever passed for the benefit of this country, and certainly at that time great expectations were roused with regard to the revolution it was to effect in employment—in the workshop, the slum and the home—in health and outlook. The compulsorily insured looked forward to cash payments in case of sickness, and free medical attention for the cure of their ailments. They were to get "9d. for 4d." and "rare and refreshing fruit." The administration of the cash benefits was placed in the hands of approved societies, and those benefits, in spite of most exacting circumstances, have been maintained at their statutory level.

I have said that the promise of the act in relation to cash benefits has been fulfilled, but I wonder whether the same can be as safely stated with regard to the health provisions. All references to the propaganda of 1911-1912 show that particular stress was laid on "*insurance against loss of health, and the*

prevention and cure of sickness," and the clause dealing with health was used as a principal weapon in the political strife of that period. The rich man's power when ill to get all that he required in the way of medical attention was promised to the working man when his vote and acquiescence to a compulsory deduction from wages was needed. Thousands upon thousands of votes were obtained on the sole understanding that the medical services under the act would be of an improving quality, and this was one of the "plums" offered to friendly society members to support the measure when it was before parliament. Since 1911-1912, matters in this respect have changed. The insurance committees called specially into existence to administer these services, have been starved of necessary finance for the purpose, and promises made time after time have not been kept. Collective bargaining with doctors has been carried through without insurance committees being parties in the negotiations, and any limitations in the development of medical benefit cannot be laid at the door of those committees. The incidence of sickness is still high, and on the voluntary side of friendly society work it is higher than before the act of 1911, with a decreasing membership paying for sickness benefits.

Large sums have been spent each year on medical benefit, yet the expenditure on sickness and disablement claims has considerably increased. Each epidemic leaves the incidence of sickness at a higher "permanent" level than previously. In the light of these facts, what has been gained? Is the provision made adequate to the needs? To any one who has closely studied the position, it is perfectly obvious that while the administration of medical benefit within the limits imposed has been generally satisfactory, there is great waste through lack of essential supplementary services. Developments and extensions have not kept pace with the need, and our complaint is directed against the unnecessarily restricted range of the present medical benefit insurance service. Lip service is paid to the old adage "Health is more important than wealth" and that "Prevention is better than cure" and yet, in national health insurance, except for a few spasmodic efforts, only the original, irreducible minimum medical benefit is assured to the insured population.

The present system, with its diagnostic and other limitations, naturally causes large numbers of insured persons to be referred to hospitals and infirmaries, which again increases the heavy incidence of sickness claims, owing to the difficulty of obtaining the speedy admission of patients. This is a matter of great anxiety and is doubtless a real factor in increasing the number of weeks of employment lost through sickness. In this respect insurance committees will be deeply interested to see how the local authorities handle their new powers to provide certain forms of assistance, other than through the Poor Law, and to reorganise the hospital facilities at their disposal. Many

national health insurance workers are particularly concerned at the evidence of the increasing number of young people on the funds. The exact figures cannot be given, but one is entitled to assume from actuarial reports that the matter is creating much unrest, and, in view of the national endeavor to raise the standard of health, the reasons for this increase merit serious thought.

From the period of infancy until the age of leaving school is reached, public health services are continually available, yet for those adolescents between the ages of 14 and 16 no provision is made. The failure to make this provision seems to me to be incapable of any justification whatever. One would have thought that in twenty-one years the unpardonable neglect of these two important years would have been remedied, and to omit medical provision in this critical period of puberty stands self condemned if health ideals are to be realized. It is therefore becoming more and more necessary to forge a link through national health insurance to bind childhood to manhood and to protect those two precious years which may make or mar the health of the young people. It will doubtless even now be said, after twenty-one years, that the time is inopportune to make changes. Was there ever a time when it *was* opportune? Therefore, despite criticism and objection, I submit that the adoption of this complete medical service is essential now and, administered on right lines, it would save its cost in the way I have briefly indicated and in other directions.

DECOURT, FERNAND: THE ABUSES IN SICKNESS INSURANCE, WILL THE MAJORITY OF THEM DISAPPEAR? *Rev. internat.*, May 1934, p. 3.

The complaints of the societies in regard to excessive expenses in health insurance are concerned with medical and pharmaceutical costs and cash benefits.

As to medical costs it will always be true that there will be more medical acts, as they are called, for any illness for the insured than for the noninsured patient. This is caused by insurance itself. Physicians seek to reduce the number of calls but find it impossible, no matter what the method of payment, so long as the insured person has the right to unlimited free care. Such a patient will consult the physician if only to get a prescription which supplies him with drugs free which he would otherwise have had to pay for.

The pharmaceutical costs will also be arranged, because the insured person does not wish to be "treated like a pauper when the insurance society is rich enough to pay." He demands expensive preparations and specialties. Neither can the practicing physician do much to check excessive cash payments. Medical science has not yet reached the point at which one

can say with certainty whether a patient who complains of rheumatism or of gastric or abdominal pains is suffering from a real disease or not.

It is not the practicing physician who should be held responsible for these abuses but human nature which leads the insured to demand that, since he has been compelled to pay contributions, he should seek to get the greatest possible profit out of the common fund.

As sickness insurance exists today, the insured does not see how economies in its administration can in any way affect him individually. The first reform that is necessary is that every insured person should know that a certain part of the contributions are reserved for him personally and that the sums expended by him are kept in an individual account, of which the balance will come to him later.

The second important reform demanded is the participation of the insured in the medical and pharmaceutical costs. When there is direct payment of the physician and pharmacist with reimbursements to the insured, this condition is easily continued. Even when there is a system of third payment, the insured may be given an account of the medical and pharmaceutical costs that have been incurred for him, which he can transmit to the insurance society, which will charge a percentage of this cost against the cash indemnity that is to be paid him.

The most powerful check on actual abuses is that the insured share in the costs and is rightly recognized to share in the savings.

DESFOSSÉS, P.: WHERE IS THE QUESTION OF SOCIAL INSURANCE IN FRANCE? *Presse méd.* 37:397 (March 23) 1929.

Desfossés discusses the complete failure of the national social insurance system in Germany. It has caused degradation of the working classes by depriving them of their independence and self responsibility. Resentful of the money forcibly deducted from their salaries, they attempted to retaliate by inventing imaginary symptoms and constantly demand examinations, medicines and vacations. The physicians, hemmed in between their employers, who demanded careful economy in dispensing public funds, and the people, who demanded needless attention, food and sea voyages, were forced constantly to practice all kinds of subterfuges. The vast amount of money spent in this enterprise was taken out of the ordinary economic channels, with a resulting decrease of national prosperity. The author delivers a challenge to the medical body of France, to profit by the example of Germany and to unite in its efforts to keep the system of social insurance from being established in France. The common people are as yet practically unaware of the law.

The upper classes are indifferent or silent. The government officials in public praise the system in vague terms and in private admit its futility and danger. The physicians alone raise the voice of protest which should become universal if France is to be saved from the misfortunes that have befallen Germany.

HAMEL, C.; JADASSOHN, J.; PRAUSNITZ, C., AND TAUTE, M.:
MEDICAL EDUCATION IN THE GERMAN REICH, Quart. Bull.
of the Health Organization, League of Nations, Geneva,
June 1932.

Like scientific medicine, medical practice is passing through a very serious crisis, one of the causes of which is specialization. The time-honored institution of the family doctor, with his all-round training, who, through years of experience, knew the inherited characteristics of the families he attended, and who was able to appreciate the psychologic imponderabilia, has steadily tended to disappear during the last few decades. In his place is found a swarm of specialists who treat isolated organs or symptoms, sometimes without even consulting the family doctor or even one another. The graver cases usually go to hospitals, and even maternity cases are more and more often treated in clinics. In this way a large number of patients are removed from the observation and treatment of the practitioner, who is thus too often deprived of the best opportunity of increasing his experience.

This is especially the case with health insurance patients, whose treatment constitutes a very important part of medical practice, since the total number of Germans insured with the health insurance funds was in 1929 about 40 millions. It is of the nature of health insurance that it should render the intimate relations between doctors and patients more difficult. Busy health insurance doctors are often unable to do more than ascertain main symptoms and to diagnose and treat cases accordingly. The popular health insurance doctor is often unable to find time for more thorough treatment. In fact, he is sometimes obliged, owing to stress of circumstances, to encourage his patients to go to a hospital, because he is unable to give them sufficiently close attention. However, many patients, and especially "light" cases, not needing treatment so much as rest, will avoid the strictly scientific doctor and consult less conscientious practitioners. The more willing a doctor is to give sickness certificates, the larger will be the number of his patients, and so there develops a vicious circle equally harmful for doctor, patient and health insurance fund.

The tendency toward specialization in medicine, the mechanization of diagnosis and treatment in hospitals, and the increasing influence of the health insurance system tend inevitably to dehumanize medicine. Another factor is the tendency to

mysticism and that longing for the supernatural and for miracles in medicine which has gained so much since the war. Doctors who have been trained on scientific and rational lines are usually unable to cope with this longing. The *wunderdoktor*, or quack, is better able to do this, and there has been a serious increase in the number of patients who desert ordinary doctors for these lay practitioners. The root of the evil is to be found not exclusively in the absence of a legislation forbidding lay treatment but at least as much in the fact that many doctors have not the necessary imagination to understand the psychology of their patients.

HILAIRE, C.: THE BALANCE OF SICKNESS INSURANCE, Presse méd. 92:1720 (Nov.) 1932.

After tracing the history of the law, he considers first the financial condition of the societies. During the first three months after the law went into operation, Oct. 1, 1930, contributions were collected but no service furnished. During the first year a large number of the insured apparently did not realize their benefits, and the demands on the societies were probably less than they will be in the future. As a consequence the societies gained a surplus of 800,000,000 francs.

The insured complain of the fact that only 85 per cent of the legal fee schedule is paid by the societies. The physicians are not restricted in the amount they charge by the fee schedule. As a result, a patient in Paris pays 30 francs for a visit and receives only 13.60 francs in return. In the country, for a visit, 15 Km. distance, he usually pays 75 francs and receives 32.10 francs. For an appendectomy he pays 1,500 francs and receives 480 francs.

"A study of the professional medical journals certainly does not indicate a hymn of praise for sickness insurance: fatigue from filling out the multiple reports, indirect but real friction with the personnel managing the societies, irritation at somewhat unjustifiable criticisms and suspicions, in brief the interference between their patients and themselves by the undesirable third party even though there is no payment by the third party, although there is a reimbursement and sometimes also a critical and hostile third party. Everywhere there is the fear of the creation, by the societies, of dispensaries and other institutions to give medical service."

"The societies complain rather bitterly of their position. They feel that their dignity is injured. They undoubtedly hoped that the law would bring them a great mass of new members. In fact, their members have grown, but very moderately. The old fraternity society member has now become a compulsorily insured person and has acquired new rights,

which means that the old societies are charged with new obligations. Instead of adapting themselves to this, the heads of the societies seem to wish to revolt."

KIRSCHNER, M.: *ON THE PRACTICE OF BENEVOLENCE*, Berlin, Julius Springer, 1931.

We physicians that are daily brought in contact with the sick and the injured and who are charged with their care have a great opportunity to observe and judge the work done in the care of the sick by the social institutions. We see the highly desirable effects of these institutions and often stand in admiration to see how great are the provisions for the care of the sick and how they are conducted almost without regard to the increasing cost. The chief defect, the cancerous evil of our social insurance, is that it is so administered that it creates in the insured a desire to be sick and to be incapable of work and to restrict their earning capacity. The insured come to believe that since they have so long contributed to the cost of insurance there comes a time when they have a right to receive some money from it. Only a few of the workers realize that the existence of an insurance system depends on regular payments from all in order that the individual may on special occasions obtain something from it.

In this way the ominous will to be sick is artificially created and social institutions many times actually put a premium on sickness, laziness, exaggeration and deceit. Legal compulsion has brought a constantly increasing proportion of the workers within the influence of these institutions. Many times Germany has been compared to a great lazaret, or home for cripples, where each one 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 a social pensioner.

It might be thought that if physicians desired they might be able to do away with these evils of insurance by making strict decisions as to whether and how far each person is sick or incapable of work. That, however, is an impossible presumption. It is not the natural function of the physician to fight out the battle which a bad insurance system has created between insured and insurers. It does not harmonize with the essential relation of confidence between physician and patient. The physician would then be compelled in advance to put an unfavorable interpretation on every feature of the sickness and to approach the patient not as a physician but rather as a public official, a detective or a policeman.

The sum of all the contributions that a laborer in the course of his lifetime pays, or has paid for him, amounts to about 15 to 17 per cent of his income.

KOCH, F.: FRENCH VIEWS OF SOCIAL INSURANCE, *Deutsche med. Wchnschr.* 55:491 (March 22) 1929.

The author refers to articles on problems of social insurance and on the situation of the French medical profession that have appeared in the *Presse médicale*. In one article, Liek's views on the disadvantages of social insurance are discussed. In another article, on social insurance and economic policy in public health institutions, Destouches considers the foundation of sickness funds as the first step to "socialization." He thinks that enforcement of the present system should be the response to the intended socialization, and not a passive resistance. He stresses that a federal organization of the medical profession should consider the interests of the employers and not appeal to "social principles." Organization of "work physicians" is suggested whose duties will consist in going round in order to observe patients when they are working or to detect malingering. Another group of "sickness fund physicians" will be assigned to treat patients confined to bed; the two groups of physicians ought to be in connection with each other. Koch thinks that the present form of social insurance proved to have a disadvantage called by Liek "sickness cultivation." The rôle of physicians should not be that of an executive of the sickness funds and their economic interests but should be limited to that of experts in matters of national health. Organization of a chamber of physicians is suggested, among the disciplinary measures of which prohibition of practice for one year or permanently is considered.

KOCH, F.: INSURANCE OF MIDDLE CLASS POPULATION, *München. med. Wchnschr.* 74:1886 (Nov. 4) 1927.

Koch stresses the fact that the medical profession ought to protect not only its economic interests but also its cultural level. Contrary to Nassauer's individualistic view, the author thinks that the ethics of the medical profession, as those of any other social group, is connected with the general culture. The origin of medical ethics goes back not to the hippocratic oath but to the social ethics of the church in the middle ages, and was of a patriarchal and charitable character. Medical culture developed then in large cities because physicians were practicing there. In the little towns, medical help was provided by barbers and by wound doctors. Medical activity of a "house physician" had a mercantile character. Liberation of the medical profession in an independent social group occurred in the nineteenth century, when the economic and social conditions changed under the influence of the capitalistic and social movements. Further changes in the economic condition of the medical profession were brought about by the organization of social and of sickness insurance. Medical care provided for

the need was no more a matter of charity, owing to the activity of sickness funds. At the present time there is a tendency to enlarge the circle of the insured population by a compulsory insurance of the middle class. Private sickness insurance companies are a new type of insurance. The author thinks that the medical profession will not be able to oppose the extension of social insurance more than it was able to oppose the organization of federal insurance. The financial situation of physicians can be improved through organization of sickness insurance and private fee adjustment bureaus. Such bureaus do not involve schematization of medical fees because the financial situation of the patient and the physician's qualifications would be considered there. The bureaus appear to be the only way to protect the economic independence of physicians against such a powerful institution as are the sickness funds.

LIEK, E.: INDEPENDENT PHYSICIAN AND INSURANCE PHYSICIAN, München. med. Wchnschr. 75:2014 (Nov. 23) 1928.

The majority of German physicians are now striving to be admitted to insurance practice, because 95 per cent of the German physicians are dependent on income from insurance companies. However, many of those who are insurance physicians are dissatisfied. This discontent is not due mainly to overburdening with work, nor to inadequate fees, since the average income of an insurance physician is about 9,000 marks. Too much writing of reports is also not a major objection, since bureaucracy is now found everywhere, even in countries that boast about their liberty. What is found extremely annoying is the constant supervision and control. The author cites examples that illustrate this. Physicians are called to account because they have prescribed medicaments that the authorities thought were not absolutely necessary. The decision of a physician whether a patient is able to work or not is questioned in many cases. Liek further stresses the demoralizing influence of the insurance system. He points out that the insurance companies have changed the relationship between the physician and his patient. Many patients simulate diseases in order to gain economic advantages, and if the physician wants to preserve his integrity, and does not comply with the desire of the patient, he will find his practice steadily diminishing. Many patients are more eager for the sickness certificate and for the support of the insurance than they are for recovery from their frequently simulated ailment. It was hoped that the unemployment insurance would do away with much of the simulation evil and would bring to the physician only those who were really in need of medical aid. This expectation has not materialized, however. One should also not overlook the significance of the patient's will to health. Without this the physician's

work is largely in vain, and considering this, one can realize the shortcomings of a system in which a patient derives greater advantages from being ill than from being well. The insurance system has also a demoralizing influence on the insurance physician. The author shows to what trickery physicians will resort in order to obtain fees for treatments that are not sanctioned by the insurance company. Because the insurance company does not pay for gold fillings, six to eight other fillings are billed instead of the one gold filling. Or a physician who has had charge of a confinement finds it easy to put the newborn infant on his list of patients by declaring that the infant required resuscitation treatment. The insurance patients as well as the insurance physician no longer consider defraud of the insurance company as a crime, but simply as an expediency which it is wise to take advantage of. The patients request the physician to make false statements, and a physician who wants to remain honest loses his patients. Many physicians prefer a position in an institution to practicing as an insurance physician. They prefer being in civil service rather than having a private practice with insurance patients, because in the latter position they suffer all the disadvantages of civil service without having any of its advantages. The author deplors that the insurance system is extended to ever larger portions of the German population, and many physicians no longer wish to fight the further extension of this system that gradually demoralizes both a strong nation and the medical profession. Some advocate the insurance system, allegedly because of their sympathy for the poorer population. But in most cases one finds that those who advocate it do so because they derive material advantages.

LIEK, E.: INDEPENDENT PHYSICIAN AND INSURANCE PHYSICIAN, München, med. Wchnschr. 76:159 (Jan. 25) 1929.

This paper is a rejoinder to Möring's criticism of Liek's first paper. Liek admits that in his first paper he stressed only the disadvantages of the social insurance companies because he thinks that the disadvantages outweigh the advantages. However, in several books that he has published on this subject he has also pointed to the advantages. He takes exception to Möring's statement, as if he had made it appear that insurance physicians are necessarily inferior. On the contrary, he admires the valuable work they are doing under unfavorable conditions. He cites statistical evidence, which proves that sick insurance companies are exploited by workers, and are taken advantage of as unemployment insurance. He further gives excerpts from a pamphlet in which the alliance of societies of German physicians object to the further extension of the insurance system, and in which they deplore the financial losses,

but more yet, the fact that their professional liberty is infringed on. He opposes Möring's opinion regarding the fact that present day wage scales do not permit a retrenchment in the insurance system, and calls attention to enormous costs of the insurance system. It is pointed out that the average worker is obliged to spend about 15 per cent of his wages for insurance and in some organizations the insurance expenses reach as high as 30 per cent. Thus even the most industrious worker remains poor. It is true that the German economic conditions cannot be compared to the American economic conditions. However, what is more important is that in America a different spirit prevails. The German insurance system is pure Marxism, whereas in America even the poorest worker considers prosperity and ownership as something desirable and within his reach. Liek thinks that social insurance is based on principles that are contrary to biology, and he thinks that it is more advisable to abandon the system than to extend it further. He calls attention to a book by Hartz, who wishes to substitute an enforced savings system for the present form of social insurance. Although Liek was formerly principally opposed to such an obligatory savings system, he now, after reading Hartz's book, considers it a possible way out from the chains of the insurance system.

LIEK, E.: INFLUENCE OF SOCIAL INSURANCE ON HEALTH OF COMMUNITY, *Schweiz. med. Wchnschr.* 60:466 (May 17) 1930.

The author states that it cannot be denied that the idea on which social insurance is based is excellent, worthy of a civilized people and, under the existing conditions, that it was necessary. Old physicians, who remember the time before insurance companies were in existence, describe deplorable conditions. An illness of longer duration or an accident of the supporter of a family brought families into bitter want and misery. The author himself recalls the time when rural laborers were insured against accident but not against sickness, and the insurance company gave aid only after thirteen weeks had expired. During this time, however, many a bone fracture healed crooked, and many of the poor had to suffer, because the money was lacking to consult a physician. This was changed when sickness insurance was extended to the rural districts. Insurance now is an effective protection for every worker. Early medical treatment is advantageous not only for the individual but also for the community, especially in the case of infectious diseases. If one goes today through the well equipped hospitals, accident stations and institutions for tuberculous patients, one cannot deny that the progress is remarkable. And like disease and accident, so also old age, invalidism and unemployment have lost much of their former terrors.

This idea of insurance is not entirely modern. As early as the thirteenth century mutual insurance companies existed among the miners and also among the organizations of craftsmen. The Krupp works had a sickness insurance for their employees as early as the third decade of the nineteenth century. And when, after 1870, Germany became gradually industrialized, the state had to give its aid. Whoever knows the deplorable condition which prevailed during the beginning period of industrialism realizes that the state has done necessary and effective work, and whoever, today, visits mines and factories and then goes into the homes of the workers will know that it is impossible to leave them without aid during sickness, accident, invalidism, old age and undeserved unemployment. However, the question needs to be answered whether or not the present insurance system aims in the right direction. The author objects that too large a percentage of the German population is insured; the newest tendency is to include in the insurance system the entire population. He also objects to the various welfare organizations, on the ground that gradually Germany will be nothing more than a large welfare station. He questions whether or not the improvement in the health of the community and in the longevity is a result of the social insurance system, because this progress is also found in countries in which social insurance companies do not exist. Among the insured population illness becomes more frequent and of longer duration, while the contrary should really be expected. Other disadvantages of the insurance system are: The mechanization and the bureaucratization of the physician's activity, and the high cost of the insurance system. For sickness insurance alone the worker has to pay 7.5 per cent of his wages. The expectation of a statesman like Bismarck, who in 1883 received the parliament's approval for the first insurance system and who aimed to overcome social unrest, has not been realized. The class struggle is now more embittered than ever. Moreover, the insurance system tends to demoralize all that are involved in it, and many far seeing persons recognize in the social insurance system not a cultural progress but a sign of decay. It is, of course, now impossible to abandon the social insurance system entirely. No sane person could advocate that. However, it should be realized that social insurance is not a cultural progress but rather the product of bitter need, and the aim should not be to include larger portions of the population in this system, but rather a gradual retrenchment.

LIEK, E.: RELATION BETWEEN PHYSICIAN AND SOCIOLOGIST,
München. med. Wchnschr. 77:603 (April 4) 1930.

Liek discusses the proposed reforms of the German federal insurance system and points out that soon the German physician will be nothing else than an employee of an insurance, dependent

and tied, and under constant, disgraceful supervision. He resents it that the sociologists who are responsible for the sickness insurance laws are mostly men who know nothing about a physician's work and who never conducted a consultation or had the responsibility for a patient. Such men are not in a position to tell physicians what to do and what not to do. He gives excerpts out of books and pamphlets published by some of these sociologists. In discussing the hospital question Liek shows that the hospitals that receive contributions from the state or from the community, and that are free from taxes, represent an unfair competition to the private practitioner and specialist as well as to the private clinic. The city of Berlin, for instance, contributes yearly 30 million marks to its hospitals. Further, the author reviews a booklet by Dr. Reermann, in which that author discusses the value and method of control examinations. In discussing the point as to whom the authorities of the sickness insurance should select for control physicians, Reermann hints that those who show up the most malingerers might be the most eligible. Liek, however, who for four and one-half years was a member of a control committee, stresses the psychologic aspects of such a position and the factors that caused him to resign. The control physician often has the feeling that he is not quite equal to his task. He cites cases in which control physicians have declared patients able to work, who died shortly after. But even more disagreeable than this feeling of not being equal to one's task is the shame one feels. The physician's work is to help the patient, not to be a detective. The control examination has also unfavorable effects on the insured, who has to submit to them. The patients are afraid, ashamed, hurt and frequently embittered. This false system insults the honest and, because physicians are not infallible, often gives advantages to the dishonest. Liek thinks that the sickness insurance system has killed one of the most important factors in diagnosis and therapy; namely, confidence between physician and patient. The sociologists are mistaken when they think that psychic influences can be replaced by laws and rules, and the author advises that those who prepare new laws and regulations regarding sickness insurance should for about one month take charge of the practice of an insurance physician. The medical profession should no longer tolerate being told by lawyers and sociologists how to conduct the treatment of patients.

The contributions to all forms of social insurance in Germany combined amount to more than five billion marks (\$1,200,000,000). When we look on this gigantic sum and realize how little the individual worker really receives from it, there is good reason to question whether the compulsorily raised contributions of social insurance are intelligently, economically and efficiently applied.

He describes the various forms of social insurance and their operation. That a fundamental reform of German social insur-

ance with which neither insured, nor insurers nor physicians are satisfied is demanded is a universally accepted and generally recognized fact. In spite of this, any one who attempts any such reform is not recognized as a reformer or as a well wisher of the German people or a friend of labor and industry, which can scarcely assert itself in international competition under the burden of excessive social institutions, but on the other hand he is denounced as being antisocial and reactionary.

LELAND, R. G., AND SIMONS, A. M.: DO WE NEED COMPULSORY PUBLIC HEALTH INSURANCE? No. Annals of the American Academy of Political and Social Science, November 1933, p. 121.

The argument for health insurance in this country is based almost entirely on the reported result of research conducted by the Committee on the Costs of Medical Care. These reports are based on a definition of illness which uses economic standards, and the difference in care is measured by the charges made for medical service. Nowhere is there any effort made to show how many sick persons sought and were denied medical service because of poverty. Cash benefit systems are directed against economic ills and do not directly concern the physician. The amount of contributions for insurance from those already at a low standard of living may be such as to lead to deficiencies in food, housing, and so on and thereby be a greater cause of illness than lack of medical care.

All systems of insurance seek to place the medical service and thereby the medical profession under more or less lay control. The medical profession believes that this makes it impossible to give the best type of medical service. Insurance has almost invariably increased morbidity. Fifty years of health insurance in Germany almost trebled the number of days lost from labor through sickness. Twenty years in England doubled the original rate. The insured in Germany showed an illness rate many times that of the noninsured. This is in part due to the fact that insurance itself by creating the desire to get something back creates actual neuroses.

Physicians gave their services to the first insurance systems, but later when they saw its tendencies they became sharply critical and now insist that in any system of insurance the medical service must be controlled by the organized profession: that there must be no third party intervention between the patient and the physician. In any of the relations connected with medical service, the patient must be allowed to choose with absolute freedom the physician from whom he desires service, and all institutions giving medical service must be under the control of the medical profession.

LYTH, J. C.: MEDICAL CERTIFICATION IN HEALTH INSURANCE, *Brit. M. J.* 1:206 (May 12, supp.) 1928.

Lyth considers some of the present certification rules, pointing out the difficulties that face medical practitioners, and offering some suggestions whereby they may be lessened or removed by the cooperation and good will of the approved society officials.

1. Change of doctor and certification. The forms under rule 2 shall not be used for any patient other than one whom the practitioner is attending as an insured person. This raises the question of the proper procedure to be adopted when an insurance practitioner is attending an insured person, not on his list, in a private capacity. If he refuses to be attended during the fortnight by the doctor on whose list he is, and requires attention from another insurance practitioner, this will have to be given privately. In such cases a plain private certificate, stating the cause of incapacity, can be, and should be, accepted by the approved society.
2. Problem of fitness for work. Differences of opinion between practitioner and patient as to the fitness of the latter for work are bound to exist. Even the ministry's circular leaves it a moot point as to exactly when the incapacity that prevents an insured person from following his usual employment, but does not prevent him from doing any work at all, ceases to be certifiable under the rules. The profession has always objected to this wording, and Lyth thinks it would have been much better had the words been "incapable of following his or her usual employment," leaving it to be decided by the regional medical officer when and whether, and if so what, other employment could be followed.
3. Rules that are too rigid. The particulars to be inserted in the certificate include the dates of examination and of signing, and the specific disease. Nonmedical opinion seems to hold that in every case of illness it should be possible for the doctor on the first examination to give a definite diagnosis, and there has certainly been a good deal of friction in regard to so-called vague wording of certificates.
4. Difficulties in diagnosis. The popular opinion that the doctor is a fool who cannot at once tell what is the matter with a patient, who he knows is not fit for work, is quite wrong. On the other hand, a skilled and painstaking effort to find out may take weeks; whereas the attitude too often adopted by approved societies places a premium on the charlatan who calls it a "chill on the liver" (whatever that may mean), and lets it go at that. Surely this is one of the instances where a little trust in the integrity of the medical practitioner would not be misplaced.
5. The use of special certificates. Rule 11 is rather a stupid one; it permits of the giving of a special convalescent certificate, to cover a period of not more than fourteen days, only if the insured person has been continuously ill for twenty-eight days before. Surely the arbitrary period of twenty-eight days is too long; and anyway the special intermediate certificate, while

not serving exactly the same purpose, might conceivably be used. Perhaps approved societies would not suffer any injury by trusting the insurance practitioners a little more than some of them do. Rule 13 allows a statement of cause of incapacity to be given as an alternative to stating the precise diagnosis on the certificate. This alternative operates only in the exceptional cases where the stating of a precise diagnosis would be prejudicial to the patient. The procedure to be followed is cumbersome in the extreme, and in any case it does not, and is not intended to provide for the holding up of a diagnosis in doubtful cases. 6. Advice as to additional benefits. The rule providing for the insertion of advice as to additional benefits on the certificate forms is not always understood. Curiously, this rule seems to take it for granted that an insured person in need of additional benefits (such as dental treatment) will be necessarily or usually on the sick list and in receipt of certificates, whereas this is much more usually not the case. The form of certificate for use on the death of a patient seems to have been drawn up with less consideration for the necessities of the occasion than the various other forms required. It provides for the insertion by the doctor of a number of quite unnecessary details, such as the date of the last certificate and various numerals showing the deceased's society, branch, and number, all of which can readily be found by referring to the previous certificate issued; and further, the wording is curiously vague, as it is addressed "To ——," a blank individual, without any instructions as to what person's name or designation is to occupy the blank.

MEDICAL CARE FOR THE AMERICAN PEOPLE, THE FINAL
REPORT OF THE COMMITTEE ON THE COSTS OF MEDICAL
CARE, Oct. 31, 1932.

The first Minority Report made the following recommendations:

I. The minority recommends that government competition in the practice of medicine be discontinued and that its activities be restricted (a) to the care of the indigent and of those patients with diseases which can be cared for only in governmental institutions; (b) to the promotion of public health; (c) to the support of the medical departments of the Army and Navy, Coast and Geodetic Survey, and other government services which cannot because of their nature or location be served by the general medical profession, and (d) to the care of veterans suffering from bona fide service-connected disabilities and diseases, except in the case of tuberculosis and nervous and mental diseases.

II. The minority recommends that government care of the indigent be expanded with the ultimate object of relieving the medical profession of this burden.

III. The minority joins with the Committee in recommending that the study, evaluation and coordination of medical service be considered important functions for every state and local community, that agencies be formed to exercise these functions, and that the coordination of rural with urban services receive special attention.

IV. The minority recommends that united attempts be made to restore the general practitioner to the central place in medical practice.

V. The minority recommends that the corporate practice of medicine, financed through intermediary agencies, be vigorously and persistently opposed as being economically wasteful, inimical to a continued and sustained high quality of medical care, or unfair exploitation of the medical profession.

VI. The minority recommends that methods be given careful trial which can rightly be fitted into our present institutions and agencies without interfering with the fundamentals of medical practice.

VII. The minority recommends the development by state or county medical societies of plans for medical care.

It considered the emphasis placed on community medical centers to be far beyond any possibility of the ultimate value of such centers. It criticized industrial contract and corporate practice and considered county medical society clinics as an important development in solving the problems of medical care.

Voluntary systems of health insurance have everywhere failed and are being replaced with compulsory systems, which are now under trial. There is still no definite proof that under these systems the costs of medical care have been reduced or that the new evils to which they give rise are preferable to those which they are supposed to abate.

One of the reasons for increased cost of medical care under insurance systems arises from the fact that the number of persons sick and the number of days sickness per capita always increases under any system of insurance.

The Majority Report in many of its recommendations for group practice and group purchase and in its emphasis on what may be called "mass" practice instead of individual practice has completely lost sight of its own postulate that personal relations between the physician and patient are important.

The Minority Report urges the development by state or county medical societies of plans for medical care and agrees that any such plan must have the following safeguards:

1. It must be under the control of the medical profession. (A "Grievance Board" to settle disputes, having lay representation, is permissible and desirable.)

2. It must guarantee not only nominal but actual free choice of physician.

3. It must include all or a large majority of the members of the county medical society.

4. The funds must be administered on a nonprofit basis.

5. It should provide for direct payment by the patient of a certain minimum amount, the common fund providing only that portion beyond the patient's means.

6. It should make adequate provision for community care of the indigent.

7. It must be entirely separate from any plan providing for cash benefits.

8. It must not require certification of disability by the physician treating the disease or injury.

MERKLEN, P.: THE THREE CURRENT ISSUES OF SOCIAL INSURANCE, *Presse méd.* **37**:1537 (Nov. 23) 1929.

Merklen considers the following as the three chief issues at the present time: 1. Indifference, a tendency to disregard the law and its consequences, believing that it will be of little or no importance in the end. 2. The failure of the law to accomplish in practice the purposes that led to its adoption, because of abuses, misconceptions and economic and political difficulties. 3. The method of participation of patients in the medical service of the system. The author feels that this is the really practical issue of the three. He favors the use of a ticket issued by the insurance organization to the patient, which he presents to the physician. This enables the physician and the patient to come together as individuals and thus helps to keep alive the personal and moral qualities that have always been associated with the practice of medicine.

OLIVER, THOMAS: THE HEALTH OF THE WORKER OF TODAY, *J. State Med., London* **38**:455 (Aug.) 1930.

In a group of 500,000 insured persons, Sir Walter Kinnear found, on comparing the experience of 1927 with the year 1921, that in 1927 the claims of male members had risen by 41 per cent, those of unmarried women by 60, and those of married women by 106 per cent. In 1921, fourteen out of every 100 men claimed sickness benefit; in 1927 the proportion had risen to twenty-three. Among unmarried women the respective proportion were twelve and twenty-one, and among married women nineteen and thirty-eight. One hardly sees why, with all the efforts that have been made to improve the health of the community, claims of illness should have increased by from 60 to 100 per cent within the space of six years. Since 1924 these claims have been rising, partly it may be owing to the

general industrial depression; but, as against this must be placed the fact that the claims are out of all proportion to the increase in unemployment, it is clear that some other explanation must be sought for. A similar opinion from an equally authoritative source has been voiced by Alderman H. J. Blake-way at the annual conference of the National Deposit Friendly Society. This society has a membership of more than 1,000,000. He informed his audience that within the last thirty years the average duration of sickness had increased from sixteen and one-half days to twenty-eight, and this without there being any marked percentage increase in the number of claimants.

Reviewing the subject generally, it may be said that the health of the workers of today is better than it was half a century ago; the conditions under which labor is carried on have improved, the hours of work have been shortened so that the working man has more rest and leisure than previously; also that but for the industrial depression matters would have been still better than they are. The one circumstance that stands out prominently and calls for special comment is the lengthened duration of sickness and the greater length of time taken to recover from wounds and fractures than formerly, notwithstanding improved methods of medical and surgical treatment and despite the fact that there has been no corresponding increase in the number of claimants. As the types of illness from which the working classes suffer have not changed and there has been no recognizable impairment of their vital resistance and power of recovery, it is clear that, apart from the aged members, it is not the duration of the illness per se which is the demeaning agent but the period given to convalescence being unduly protracted.

PRÉSSE MÉDICALE: EFFECTS ON MEDICAL PROFESSION OF
SOCIAL INSURANCE IN GERMANY, *Presse méd.* 37:1487
(Nov. 13) 1929.

Merklen and Wolf show that social insurance has a disastrous effect on the medical profession. The rigid restrictions of the administration with reference to expenditure of funds have led to modification of the attitude of physicians toward fees and prescriptions. The emphasis is placed not on the best therapeutic methods but on returning the patient to his work as quickly and economically as possible. In fact, the difficulties thus encountered almost make necessary a certain type of physician especially trained for social insurance work. Scientific medical progress and research are, therefore, considerably hindered. Moreover, the moral contact and sense of responsibility that formerly linked a physician with his patients is eliminated by the intervention of the social insurance organization. The physician is merely a medical func-

tionary carrying out the therapeutic principles of his superiors. Because of the resulting standardization and commercialization of the profession, and the fact that the social insurance system guarantees at least a minimum living wage to physicians from the start, throngs of young men are entering the medical schools, with the result that the educational and professional standards are constantly being lowered. The medical profession is consequently gradually coming to receive less respect from the people in general.

RINK, W.: THE OBJECTIVATIONS OF INVESTIGATIONS IN INSURANCE MEDICAL PRACTICE, Deutsche med. Wchnschr. 59:1930 (Dec.) 1933.

This is a discussion of the methods to be used by a supervising physician in reexaminations to determine capacity for work. The obstacles to objectivity in such an examination are stressed. The attitude of the patient is one of hostility. In some cases there is complete refusal to answer questions and the physician must therefore draw his conclusions almost entirely from an objective investigation. It is difficult to do this in such diseases as muscular rheumatism and neuralgia. The patient has often already made himself familiar with standard tests and knows how to produce the expected reactions. He describes a number of such tests that he thinks are less familiar to the public and says he cannot here give all the instances of such diagnostic "tricks" used. (English in original.) Considerable stress is laid on possible studies of the physiognomy of the patients, although there is doubt as to its value in most cases. It is especially difficult to diagnose incipient diseases, especially any due to industrial poisons, under such conditions. He concludes that the only reliable method is close and full cooperation with the practicing physician who made the original diagnosis and has conducted the treatment. He gives a bibliography of works devoted to the subject of diagnosis of suspected simulation in sickness insurance.

ROEDER: CAUSES OF EMPTYNESS OF HOSPITALS AS RESULT OF EMERGENCY DECREE, Med. Klin. 26:1733 (Nov. 14) 1930.

It has always been observed that hospitals are about one-fifth empty during the summer months and then gradually fill up in the fall. However, since the emergency decree came into effect, the normal increase during the fall months has been considerably less. This is due to the fact that more patients stay at home because the insurance companies have reduced the con-

tributions for the dependents of the patients. Formerly the insurance companies paid a certain percentage of the patient's wages to the dependents at home. Since these contributions have been so considerably reduced, the patients feel that they cannot afford to stay at the hospital. Another cause for the emptiness of hospitals lies in the fact that since the insured person has to pay part of the expenses many patients refrain from seeking medical advice. Some physicians encourage their patients to stay at home rather than to go to the hospital, because such home cases increase their fees somewhat, since they are permitted to charge for every visit.

WEISS, CHAUFFARD, M., HAYEM, G., AND STRAUSS, P.:
THE SOCIAL INSURANCE SYSTEM, Bull. Acad. de méd.
102:653 (Dec. 17) 1929.

Chauffard points out that the contradictory opinions expressed by Weiss and Strauss are, to say the least, slightly perplexing to their readers. He feels that the chief reason for this contradiction is that they have approached the subject from entirely different points of view. Strauss emphasizes the constructive work accomplished in Germany, such as the building of hospitals and enlargement of medical and sanitary facilities; he does not take into account that the organization in Germany has become a state within a state and that a large part of the sanitary work accomplished should have been a government enterprise. Weiss, on the other hand, dwells on the moral and economic consequences of the system. The author's conclusion is the suggestion that it would be better to forget the social insurance laws, thus releasing the money formerly used for administration of the system to be employed in magnificently increasing the hygienic and medical equipment of France.

WEISS, M.: DANGERS OF SOCIAL INSURANCE SYSTEM, Bull.
Acad. de méd. 102:520 (Dec. 3) 1929.

Weiss's experience has convinced him that the medical body of France is practically unanimous in considering the social insurance system as a menace to the health of the nation and to the former high standards of the medical profession. He speaks of the lack of thoroughness with which examination of patients is often performed, of the frequency with which patients in small villages are sent to the hospitals too late to receive proper treatment, and of the lamentable neglect of patients that often results from technicalities and the many demands on the physicians. Moreover, the social insurance organization will undoubtedly become eventually a more and more powerful political force, which will be detrimental to

the accomplishing of its primary aims. Immense sums of money are and will continue to be spent in the mere organization and administration of the system; this money might be better spent in improving the medical and sanitary resources of the nation. The need for many standardized physicians and the political and economic mechanism of the social insurance organization are necessarily causing young men to hurry through medical courses without sufficient training and without the lofty ideals that should characterize the medical profession. Moreover the common demands of insured workers for unneeded prescriptions of drugs and fake certificates, which the doctor must grant if he wishes to keep his office filled, tend to lower the standards of the profession. The people thus lose faith in the integrity of the physicians in their community. Moreover, since the practice of medicine is of the same quality as the physicians themselves, the quality of the medical treatment given will gradually deteriorate. The adoption of the social insurance system, therefore, is a serious problem, one that should not be solved without a thorough consideration of all available information.

WEISS, M.: THE SOCIAL INSURANCE SYSTEM, *Bull. Acad. de méd.* **102**:653 (Dec. 17) 1929.

Weiss again summarizes the dangers of the social insurance system. He moreover disagrees most heartily with Strauss's statements (published in the *Bulletin de l'Académie* of December 3) that the criticisms of the system were merely of details and that the attacks were of a purely individual character and represented only isolated opinions. The author says that recently he has heard nothing save protestations and recriminations from insured workers, insurance officials, and the medical body.

WOLFENDEN, HUGH H.: REAL MEANING OF SOCIAL INSURANCE, 227 pp., The Macmillan Company of Canada, Ltd., Toronto, 1932.

The author is a prominent independent actuary. In approaching the subject from the standpoint of seeing that insurance principles are not infringed in any scheme which may be called "insurance," he emphasizes that "this book is intended to record simply the basic and essential facts which constitute the fabric of governmental social insurance plans as they are known today, with a dispassionate analysis of the motives and arguments which constitute their defenses and their weaknesses."

The problem of medical care is one that has given rise to a great variety of experiments. The author explains the forms of social insurance in various countries. All the available statistics show that under governmental schemes of sickness insurance there has been a steady increase in the extent and average duration of compensated sickness. Mr. Wolfenden observes that the state operation of social insurance "must always be subject to the pressure of beneficiaries and politicians, who see in it either an easy means of sustenance or an opportunity to gain political support."

Sir Arthur Newsholme is quoted as saying that "the British health insurance scheme has involved expenditures in administration entirely incommensurate with the benefits received." The author points out that "an unmistakable tendency has been evident to introduce legislation at the behest of politicians and social reformers; and frequently these classes neither desire nor are competent to appreciate either the cost or the technical actuarial and financial problems which must receive the most careful consideration well in advance if any such plan is to have a reasonable hope of financial solvency." It is stated that if such a plan were to be introduced in Canada there would be great difficulty in collecting contributions in the sparsely settled rural districts, and that in Canada there is "neither the Friendly Society system itself around which to build a plan, nor the inducement to approve a plan because of its possible assistance to such societies." The author adds that "the very definite tendency which the National Health Insurance scheme in Great Britain is developing towards a comprehensive state controlled medical service cannot be ignored."

Mr. Wolfenden urges that the most careful consideration should be given to the following list of preventive and curative measures: "(a) A comprehensive sickness registration plan; (b) periodical health examinations, not only of school children and in all educational institutions, but also in all industrial plants; (c) larger appropriations for state and local boards of health, laboratories, bureaus of child welfare, hospitals, sanatoria, asylums, venereal disease centers, district nursing centers, etc., particularly in rural districts; (d) greater attention to housing plans and the removal of unsanitary living conditions; (e) a more rational system of medical fees for the community at large, under which the manifest inequality in the cost of medical care for the rich and the poor should be materially reduced—in connection with which the coordination of a possible system of scheduled fees with greater state supervision of medical practice is now being discussed extensively; (f) continued development of all types of voluntary insurance plans, whether originating within industry, or at the suggestion of existing insurance organizations, by such means, in

particular, as group insurance; (*g*) more comprehensive investigations of wage standards, especially in the lower wage groups, with the object of determining for all classes the truth or falsity of the accusation that under present economic conditions a considerable portion of the wage-earners receive incomes inadequate for their essential requirements and for individual family protection through voluntary insurance."

STATE MEDICINE—AFFIRMATIVE

AUSTIN, M. A.: STATE MEDICINE OR WHAT? J. Indiana S. M. A. 22:317 (Aug.) 1929.

We have altogether too many welfare workers as parasites to the health work of our state and nation. We have altogether too many of our own profession using these health demonstrations as a means of advertising themselves rather than for the good they can do in their work. We are facing another problem in the self-aggrandizement of certain individuals in connection with some of our state hospitals whose enthusiasm for quantities of work causes them to overstep the bounds of propriety and utilize questionable methods to bring all who can come to avail themselves of what their missionaries term "superior service." How to provide competent medical, hospital and laboratory service for the great middle class is becoming a graver problem every day, because the inducements for purchasing luxuries are so alluring that few are able to resist the blandishments of the present-day salesman. Economists state that it requires 4 per cent of the family income to provide the minimum of competent medical care in a family, and including dentistry it will take 5 per cent, and this will not include any serious emergencies. If the bread winner in the family is incapacitated, then an operation and its expenses in a hospital will require an amount that the majority of persons cannot afford. Their expenditures for luxuries and unnecessary diversions and the so-called high standard of living leave them no surplus to provide for emergencies such as sickness. These emergency expenses could be cared for easily if the gasoline bills were reduced and one or two picture shows passed up each week, but these and the weekly trips of the women to the beauty parlors now seem a necessity that cannot be avoided. Changing conditions from agricultural to industrial economic necessities have changed every thing, including our point of view concerning morals, women's clothes, housing and feeding problems; and so will the practice of medicine also be changed, so that the great middle class may have all that the rich and the poor have been receiving in the past. If this means state medical centers and county and municipal units with full time specialists, and all home practice cared for as an outpatient department, so will it be. In my opinion, we are rapidly approaching a time when these things will be a reality even though some of us may deplore the fact.

BIGELOW, G. H.: IS THE STATE'S CANCER PROGRAM STATE MEDICINE? *New England J. Med.* **200**:438 (Feb. 28) 1929.

What is the cancer program? We will consider here only what has developed under the legislative mandate of 1926, which in its disregard of the feelings of the medical profession showed at least one element inherent in state medicine. Under the act the program was developed with the advice of medical and lay advisory committees made up of persons of astonishing quality.

1. The state cancer hospital. About a year and a half ago a ninety bed hospital was opened at Pondville where a high quality of service is given, thanks largely to the interest and sincerity of the visiting staff, the skill and devotion of the nurses, and the liberal equipment. Here persons in all stages of cancer are treated without economic let or hindrance and charges at "not more than cost." These charges are paid by the individual or the town of residence.
2. State-aided cancer clinics. There are now scattered throughout the commonwealth seventeen state-aided clinics. Others will be opened when local medical opposition can be overcome. Realizing that professional support must be obtained we have in each instance presented our program to the local medical profession. After a vote of support the appointment by the local medical society of a local medical cancer committee has been authorized. This is the committee with which the department does business. It is responsible for all the multiple administrative and medical problems connected with the clinic. In each clinic there is a social worker. In each instance there is a local cancer education committee appointed by the local medical committee. It takes care of publicity, education and advice on the more difficult social problems.
3. Cancer education and studies. From the studies following our cancer campaign of last spring, as has been pointed out, apparently one of the most specific results of our annual expenditure of some \$40,000 is to place a large number of individuals in the private doctors' offices (95 per cent of those influenced by us). This education has been handled directly by us and also through the astonishingly devoted local committees. Other aspects of this interesting matter are being studied cooperatively with the social service departments of the Massachusetts General Hospital and the Boston Dispensary. Another approach has been through general sickness surveys of communities, Winchester, Shelburne Falls and Lawrence. These give data on types of sickness and their economic distribution, the loss of time entailed, the medical care, and the like. Also, we have recently studied Wayland in an effort to advise in regard to a hospitalization problem, and at the request of the overseers of the poor of Cambridge plan a somewhat more elaborate sociologic and morbidity study on three hundred families under their care. So much for our program! Now is it state medicine? Again, what is state medicine? A definition that is much too simple

and intelligible to be correct, I fear, is that state medicine is medical service to the individual at the expense of the community. By any such definition, state medicine has the sanction of usage from the days when spontaneous generation was young or even earlier. Our city, state and federal hospitals and clinics attached thereto, our city physicians, our "private" patients in hospitals who do not pay toward interest on invested capital, the beneficiaries of industrial accidents and sickness insurance, all these are examples of service which is ultimately paid for by the community. However, there is quite another definition of state medicine. It is, I think, in the mind of many, if not most, physicians. It is in general a vague feeling not formulated in words. If it becomes articulate, it is usually so only in small groups of similarly minded cronies. It is not dignified by formal presentation in professional assemblies. Here the term "state medicine" is enough. No questions are asked. Bolshevism is rife and the anointed turn piously toward the professional east. But this vague harassing medical thought is of enormous importance since I feel it is the greatest single factor external to ourselves which renders the work of health officers futile. We must therefore try to look it in the face. It runs something like this: Eventually all doctors will be ordered how, when and where they are to give service by some remote, impersonal, autocratic, unsympathetic, unprofessional, governmental agency; for this service they are to be paid on a schedule, which it will take a course in higher mathematics to understand, and at a scandalously low wage. The dangers of this are the removal of the essential motive of individual initiative which has been the basis of all advances in science and anything else, the giving of a generally hideously poor quality of service, and the starving of all physicians. The consummation of such a vision would, of course, be an unparalleled calamity. It would seem to me that the former were a far more intelligent definition of "state medicine." Then the cancer program is unequivocally state medicine. Under wise advice we have aimed to preserve and foster all the essential individual professional initiative inherent in private practice. We have attempted to add to this all the qualitative and economic benefits which come from group action. The pressure for this grouping is being felt the length and breadth of all gainful activities in America today from the farmer to the railroad magnate. The professions have protectively claimed that as they are above commercialism they are above such pressure. Specious, thoroughly specious! The thing to worry us is not whether it is proper for the state to interfere in the treatment of cancer in this way. The people have answered that. Rather is it for us to decide whether we will put our house in order so that cardiac, arthritic and neurologic patients and the rest will get a level of service commensurate with what these same people, The People, are likely to demand, or whether through legisla-

tion they will introduce State medicine more aggressively into these much larger fields. For if the state department of public health refuses a legislative mandate, it will be wiped off the slate and a more responsive department put in its place. Therefore, it would seem that the only salvation from the hideous dream which I have parodied is for the medical profession and the health officer to solve together these great inadequacies which are making for so much popular dissatisfaction today.

CHURCHILL, S.: MEDICAL SERVICE FOR ALL, M. Officer 37:177 (April 16) 1927.

The growth of the public health service in this country has been marked by the establishment of rate-aided outpatient clinics by local authorities, where patients may obtain expert medical advice as opposed to the more generalized domiciliary treatment obtainable through the national health insurance act (which does not cover the question of residential treatment). Such specialist service is provided at the tuberculosis dispensaries, at the venereal diseases clinics, and at the maternity and child welfare clinics, and there has been a recent movement to provide consultant obstetric services for patients attending the latter in two London boroughs. Reviewing briefly the existing arrangements for preventive and curative work at the present day one finds that the former is represented by these free clinics, public propaganda, and a little teaching in the elementary school; the curative side exists in the form of domiciliary treatment by the general practitioner and dispensaries, and institutional treatment by beds provided by local authorities, including the poor law and voluntary hospitals (230,232 equals 6 per thousand of the population). In considering any future scheme of development one must take into account the results of such inquiries as have been made by various bodies representing the different interests involved, such as the British Medical Association and the national health insurance act. In 1919 Dr. Addison, then minister of health, set up a consultative council "to consider and make recommendations for the systematized provision of medical and allied services." This council issued an interim report in May, 1920. Briefly, this report desires to extend the availability of all forms of medical service, to transfer the infirmaries to the local authority, and to extend the existing services in two important directions, namely, those of physical culture and by means of recuperative centers. The British Medical Association, representing 29,000 general practitioners, published in October, 1926, "The Policy Affecting Hospitals," recommending that the principle of the local voluntary hospital commission should be approved and their scope extended so as to make them the

coordinating bodies for all accommodation in the area, including voluntary, municipal and poor law infirmaries. They point out that under section 131 of the public health act of 1875 any local authority can build hospitals for the sick inhabitants of the district, and advise that where consultation is needed on this point the local organization of the British Medical Association should select a representative. If such a municipal hospital is established, beds should be set aside for private patients paying a fee and such patients can be treated by the general practitioner, the method of admission to such hospital being only through the recommendation of the practitioner. The voluntary hospital's problem is considered from two points of view, namely, that of the charitable institution with a free medical staff and that of paying patients, who would contribute to the cost of their nursing and medical attendance. The report of the National Health Insurance Commission, published in 1926, recommends consultations at patients' homes by the "approved expert" only after the proposal has been submitted for approval to the medical officer appointed for the purpose! The report of the labor party, in March, 1922, deals exclusively with the question of bed accommodation and urges that hospitals should form part of an organized public health service controlled by the Ministry of Health, but administered by local authorities. Among other recommendations, they also advise the acquisition of the poor law infirmaries, and they quote from the report of the voluntary hospitals commission that of the 92,000 beds in poor law infirmaries, 20,000 are empty in the winter and 30,000 in the summer months. The dangers of state aid lie chiefly in the multiplication of forms and "red tape," but there is also some risk that initiative on the part of the public health officer will be curbed because excessive control and of the obvious lack of freedom. Reactionary authorities, as every public health official knows, can make progress difficult and the life of a medical officer a burden. In any scheme of medical service which is to be both preventive and curative, domiciliary and institutional, there must be an efficient control of all public health activities, and a proper administration of the laws affecting housing, contamination of food, water supply, pollution of air, control of epidemics, factory legislation. It is sometimes urged that if everyone were in receipt of a living wage there would be much less need for public health action, but the community will obviously always require control and supervision of its food and water supply, drains, dust destruction, and many other necessities which cannot be left to private enterprise. Industrial hygiene in the future will have to play a much larger part in securing good health for the worker and preventing breakdown in middle life. Legislation affecting health must be obligatory and not permissive.

GRANT, J. B.: STATE MEDICINE—LOGICAL POLICY FOR CHINA, *Nat. M. J. China* 14:65 (April) 1928.

The medical policy to adopt for China should be one of state medicine. What initial steps should be taken to insure the fullest returns on such a policy? The essential one would be securing efficient personnel. Such personnel should equal in training and administrative ability the best medical men in the world. Without adequate training they would undertake measures blindly and mechanically. Without administrative ability the obstacles inherent to the establishment of a new social phase cannot be overcome. Once a policy is determined on it is essential that political leaders appreciate that medical affairs are nonpartisan and scientific in nature and, although the personnel are available, they represent such a small group that after being chosen on merit alone, they must be afforded security of tenure, removable only for cause. There are certain preliminary administrative steps. The most important would be the establishment of a centralized medical authority with power to execute the adopted policy on a nation-wide scale as conditions gradually permitted. There are four distinct types of nation-wide medical administration: national, provincial, urban and rural. Given a central medical authority and staffed by an adequate personnel, the latter would draw up an initial program for each type of administration based on diagnosis of the community medical needs. Proceeding in this manner, China would undertake a scientific medical policy which would proceed from a definition of the problem involved to the meeting of the problem by the most efficient application of medical science within the scope of practical limitations. The result would be a graded program based on appreciation of the existing status of the country, extending with concurrent changes along economic, industrial and educational planes in the society to be served medically.

HAIGH, G. W.: IN DEFENSE OF STATE MEDICINE, *New England J. Med.* 202:1078 (May 29) 1930.

Haigh has been engaged in the private and hospital practice of medicine since 1912, with the exception of nearly two years during which he served as a medical officer in the navy. During those years, he gained an insight into the functioning of a cooperative medical service in contrast to the individualistic form of civilian medical practice. Soon after having resumed his practice he began to realize the advantages of a government medical service over the chaotic conditions of private practice and gradually became a strong advocate of state medicine, a free, universal, complete medical service. It is generally admitted that modern medicine, on account of its growing and multiplying branches, demands cooperation. Cooperation can

be secured and assured only through organization. Economic organization of physicians has not kept pace with the rapid progress of the medical sciences. It is limited to the larger public health departments and hospitals. It should be extended to cover the whole realm of medicine, which comprises two complementary divisions, of which one, preventive medicine, waxes, as the other, curative medicine, wanes. The fundamental problem, therefore, is what sort of organization, by unifying and coordinating the growing and multiplying specialties of preventive and curative medicine, will provide for the people the best service for both preserving and restoring their health and vigor. Of the possible medical bodies that might furnish such service, there are four: a priesthood, a private corporation, a public corporation, and a government corps. The first, a priesthood, can hardly be created but must arise spontaneously through the inspiration of a leader and his disciples striving to effect a dire reform. To await the advent of any such order to reform medicine would be not only gross delinquency but also rank folly. Private corporations or partnerships would be somewhat comparable to private group practice, which has not yet demonstrated its suitability for the middle and lower classes. This form of medical service extended to the different classes of society could with difficulty survive the initial period of establishment because of the indefinite amount of capital necessary to enable the competing companies to prove their superiority over the other health agencies as well as over one another. They would not, moreover, eliminate the deplorable waste and excessive cost in a service so essential as one for health and accidents. No more adaptable as a cooperative system of health and accident would be a public corporation corresponding to the public utilities supplying electricity, gas and transportation. The migratory nature of many people would preclude a corporation with a field of operation less extensive than a county. The only means of completely and efficiently organizing the profession for the betterment of medical practice, therefore, is a government bureau of medicine and surgery. Since the medical profession has signally failed to furnish proper service at a reasonable cost, and the individual practitioner is devoting his attention chiefly to the cure rather than to the prevention of disease, it behooves the people through its representatives to adopt such a system as this bill is designed to found. Such a public service necessarily, as our public schools do, would compel its beneficiaries to forego their choice of any individual physician and to accept the offices of the one or more medical men designated to serve them. This would not entail any hardship but would be a distinct advantage in this day of specialization, when so many persons need to be directed to the source of the best treatment without the delay that so often results if they try to choose the best qualified doctor. In any profession to which only the learned should belong, an opportunity to work intelligently, itself, suffices as a stimulus to effort. A

decent living is sufficient material compensation. For several decades, in fact, most contributions to the advancement of medicine have emanated from clinics, laboratories, or institutes manned by salaried personnel working together. Even members of the medical profession financially independent, furthermore, have shown initiative and energy in the pursuit of such scientific research and in the establishment of renowned clinics, dependent on team work. Since 1906, in fact, the professional standing of the medical officers of the United States Navy as well as those of the army and federal Public Health Service, has been acknowledged by the American Medical Association to be above that of the civilian physicians in general, because the former are admitted to fellowship automatically, by virtue of their commissions, whereas the latter are eligible only by meeting certain qualifications. Since only representative graduates in medicine enter these federal services, the organizations, themselves, must foster a grade of practice higher than that of civilian doctors, who, in their need or in their greed are influenced by monetary considerations and distractions. Moreover, it was to be observed by those physicians serving in the navy for the duration of the World War that the regular naval personnel had the utmost confidence in its medical officers. Some of these who were financially able and physically free to consult eminent civilian doctors gladly availed themselves of the services of their own doctors. Another objection to government medicine is its alleged prohibitive expense. Just reflect on the extravagance of the present incoherent, multifarious health agencies in our commonwealth. First, there are the state organizations. Second, the federal health services, public health, child welfare and maternity, and also various private national societies and institutes of hygiene and medicine with state branches. Third, the local boards of health with their hospitals for contagious diseases, and the school health department, police and private ambulance services, diverse hospitals, municipal as well as private, charitable and industrial, general and special, different health centers, district nursing societies, Red Cross workers, private physicians, and nurses, pharmacists, masseurs, cultists of nearly the fifty-seven proverbial varieties, mediums, quacks, abortionists, herbalists, fakers, and dispensers of "patent" medicines. As the value of hygiene comes to be better appreciated and as the progress of civilization renders mankind economically more and more interdependent, the functions of the civilian physician become identical with those of the naval medical officer; these are, primarily, to keep the personnel fit for duty and, secondarily, to restore them to fitness for duty. Without an excellent organization the medical corps of the navy and army would surely have broken down during the World War under the strain of the sudden and vast recruiting of their respective numbers. That they met that supreme test nobly, no one would dispute. Then, why cannot that organization be applied to civilian prac-

tice? In the adaptation of this government medical service to the public the unit would be the district hospital with such different departments as eye, ear, nose and throat, orthopedic, obstetric, pediatric, genito-urinary, neurologic, mental, convalescent and incurable. It would vary according to the populousness of its territory. In the largest cities the different departments might be represented by institutions separate from one another but closely affiliated with the general hospital, which would provide a clearing house for patients and a headquarters for the personnel and the permanent health records. Besides, there would be auxiliary health and accident stations in factories and shops where enough people were employed, and also in rural communities too remote to be served directly by the central hospital staff. Temporary relief stations might be set up for celebrations, exhibitions, athletic contests, and entertainments when people gathered in large enough crowds. Mobile field companies might be dispatched expeditiously for service among communities stricken with epidemics or catastrophes. Medical officers on the hospital staffs would minister to those unable to visit the outpatient clinics, whether or not in need of hospital treatment. Eventually, however, nearly all patients incapacitated by curable diseases or remedial injuries would be confined to the appropriate hospitals. Over these medical groups would be a central professional bureau like that of the navy. This would be manned by medical officers and their assistants under the direction of a medical administrator, who alone would be appointed by a layman. In order to eliminate politics from the operation of this service he would be selected by the governor only from those medical officers of the two or three highest ranks. This state health department would encompass the existing commission of public health and the medical duties of the industrial accident board and the department of public welfare. The personnel would comprise doctors, dentists, nurses, pharmacists and chemists, technicians, and any others that should be found advantageous. The professional members would be paid approximately according to the schedule of pay for the medical personnel of the navy. The salaries with the usual allowances for living quarters would be determined by two factors, the length of service and the rank. Promotion would be governed by examination. Every one of the personnel would be obliged to devote his full time to the service. Full time contract medical practice is profitable and inspiring. The proposed government bureau would supply to any and all a free, universal medical service, which might eventually be just as compulsory as our educational system, since no patient should be permitted to lose his life or his health through ignorance or fanaticism. State medicine, furthermore, would remove for many the present inhuman impediment to prompt diagnosis and effectual treatment; namely, the expensiveness of competitive medicine. This organization would assume entire responsibility for returning patients to work as expeditiously and as impar-

tially as possible. It would insure patients receiving an examination at the end as well as at the onset of any illness or injury severe enough to keep them away from their usual duties. It would guarantee physical examinations at whatever periods were deemed desirable for those of different ages and of various occupational hazards. Free medicine, alone, would not only make available to every patient all the resources in knowledge and skill of the whole system but would also furnish the means by which they would become most accessible, medical advice ad libitum. This system, moreover, would correct the incongruous and unreasonable positions of doctors in the present chaotic condition of medical practice. The aspirants for specialties would be trained only after thorough experience in general medicine. The older physicians in general would not be constrained to do things in which they had ceased to be interested and which they did more proficiently earlier in their careers. Several other glaring evils of competitive medicine would be abolished by systematic cooperation. There is another fault state medicine would remedy, weariness and brain fag, caused by the necessity of the individual physicians having to render personal service to their patients at all times of the day and night. Haste with its baneful consequences would also be discouraged by collective practice employing the economic principle of the division of labor. Carelessness on which individualistic practice exercises no direct check would be curbed by state medicine.

McCAULEY, MRS. E. S. H.: FUNCTIONS OF STATE DEPARTMENT OF WELFARE, Pennsylvania M. J. 31:299 (Jan.) 1929.

The Department of Welfare was created by an act of assembly, May 25, 1921. It covers a wide field of activities and functions through four bureaus—the Bureau of Assistance, the Bureau of Children, the Bureau of Mental Health, and the Bureau of Restoration. The Bureau of Assistance supervises state-aided medical and surgical hospitals; county, borough, and township almshouses; homes for the aged; state relief in disaster; and administers the act regulating the solicitation of funds. The director also acts in a social service consultant capacity. The Bureau of Children supervises institutions and agencies caring for dependent, neglected, and delinquent children and the mothers' assistance fund. It administers the law with regard to the importation of children, licenses baby boarding homes, assists and standardizes clinics for the crippled child, and gives consultation and educational service in child welfare. The Bureau of Mental Health supervises institutions and agencies for the mentally ill, mental defectives, epileptics, and inebriates; provides supervision for the occupational

therapy department of each institution; authorizes transfers of patients; conducts investigations of aliens prior to deportation; conducts mental clinics; administers mental health laws; provides psychiatric and psychologic consultation service for correctional institutions; and provides community supervision and group surveys of mental patients. The Bureau of Restoration supervises state, county, and borough institutions of the penal and correctional type; assembles criminal statistics; superintends the transfer of prisoners; and conducts prison industries and educational activities. Closely allied with the activities of this bureau, but directed by a general superintendent, is the management of the prison-labor industries. An allied agency of the Department of Welfare is the State Council for the Blind, which supervises, coordinates, and supplements work for the blind; serves as a bureau of information and a clearing house; furthers more adequate training and placement of capable, able-bodied blind adults; develops home teaching; secures some form of relief for the needy blind, and more adequate provision for the blind feebleminded; and formulates the general policy and program for the prevention of blindness and the establishment of sight-saving classes in the public schools. The council also maintains a register of the blind of the state by surveys of the counties carried on by its field representatives. Through staff specialists, the department also maintains administrative control over state-owned institutions; furnishes service to state and state-aided institutions in standardizing accounting systems; solves engineering and agricultural problems; organizes and promotes nursing facilities and training; and develops scientific nutrition and food administration. The department compiles welfare statistics, conducts research and activities for improving inter-racial relations, and promotes community welfare organization. It conducts educational and consultation service in the entire welfare field. There are 898 institutions and agencies which come under the advisory and supervisory care of the department. No group in the state is in a better position than the members of the medical profession to have a comprehensive understanding of the work being done through the Bureau of Assistance in the state-aided hospitals. The high grade of service established when the system of appropriating to the hospitals on the basis of a per diem rate for service rendered to those whose circumstances warranted free service has been maintained and improved. Four experienced medical social workers make quarterly visits, check the hospitals' lists of those entitled to free service, and advise and assist in provisions for the social service problems discovered in the course of the checking. Such problems are discovered in the care of the chronically ill, the permanently handicapped and those needing rehabilitation, crippled children, family distress, unmarried mothers, and many other cases that arise in all hospitals whether large or small. Social service is

necessary if a hospital is to discharge its full duty to the community and to take its part in a program of prevention. It will be quite impossible to evaluate the service rendered by the personnel of this bureau in connection with the eighty-one almshouses in Pennsylvania's sixty-seven counties.

McINTOSH, J. W.: A DOMINION MEDICAL SERVICE, *Canad. Pub. Health J.* 21:177 (April) 1930.

By a dominion or Canadian medical service is here meant a group of medical men who are employed in any of the public services requiring men with training in any branch of medicine. This is not state medicine, so-called, which proposes to do away with private practice and enroll physicians in practice under the state. The idea behind this is to get away as far as possible from men in private practice holding appointment for public medical service. It suggests using full time men for all public medical positions, whether federal, provincial or municipal, wherever feasible. In a federal service, as far as possible, through the coordination of the commission, the work among the Indians and the Esquimaux, the medical requirements of the Royal Canadian Mounted Police, the port medical officers, the medical services on public works construction and in connection with the C. N. R. employees, and, as far as practicable civil service medical examinations, should be placed under full time men, registered in the proposed medical service, who, of course, would also be available to take on whatever medical duties, under provincial or municipal authorities, might be available or required at or near the same points or areas. In considering the question of a dominion medical service in connection with provincial affairs, one enters the arena of preventive medicine, for as already pointed out, with the individual province lies the chief control of public health, either directly under the provincial health department, or indirectly under the municipalities. A medical service, with full time men linking up all these various services, some of course already so manned, would go a long way towards separating the work of public health in its various phases from the often haphazard attention it receives at the hands of men whose main outlook is in private medical practice. Where now there may be a minor federal appointment for example, going to a part time man, often, by a properly coordinated service, it, together with provincial or municipal appointments, could be adequately and satisfactorily handled by full time men in the service, holding thus joint appointments, whether federal, provincial, municipal or other.

McMASTER, A. B.: LOCAL GOVERNMENT AND MEDICINE, Brit. M. J. 2:165 (Oct. 12, supp.) 1929.

The first local government act was passed in 1871, and under it was constituted the Local Government Board as we all knew it until after the great war, when the Ministry of Health took over the administration. Consequent upon the new act, however, from April 1, 1930, two authorities only will be responsible—the county council and the local sanitary authority. Power is given to each county council to provide hospitals for the use of the inhabitants of the county. To ensure at this juncture that there is a representative from the governing body of each hospital in the county, and representatives from the medical staffs in the county available to be called together for consultation with the county council, seems to me to be the sound line of progress. (Since I wrote the foregoing, the branch council has decided that the consultative medical committee for the voluntary hospitals in the county shall be a joint committee composed of members of the branch and members of the local medical and panel committee in Kent.) County councils have also to decide whether certain services in the future will be provided by way of poor relief or under the specified acts. From April next, functions under the vaccination acts will be discharged by county councils as functions relating to public health. The provision of medical treatment for the individual by the state was confined for many years to that provided for the sick poor, either in their homes or in institutions. This facility was mainly curative. The next stage reached was that for the cure and prevention of the infectious diseases, when isolation hospitals owned by the local sanitary authorities took the place either of the typhoid and diphtheria wards of general hospitals or the old fever blocks of infirmaries. The last twenty-one years has witnessed the steady increase in the number of directions in which legislation has extended the responsibility of local authorities for organized schemes for treatment. For the school child many specialized services are available; for the tuberculous patient, the patient with venereal disease, the epileptic, and the ament, institutional treatment of one form or the other is arranged; while since 1919, what originally started as an effort to reduce the high infantile mortality of the eighties and nineties has extended to a far-reaching “new humanity” movement for maternity and child welfare. When the many medical problems that call for rearrangement under the new act have been solved, there will be still greater cooperation between the curative and preventive branches of the profession.

MITCHELL, J. A.: THE MEDICAL NEEDS OF THE PEOPLE AND THE PRESENT SYSTEM OF MEETING THEM, *Brit. M. J.* 2:145 (September 21, supp.) 1929.

The results of the present system in the union are an enormous sale of "patent" and Dutch medicines, and a great vogue of quacks of various kinds; also that a large percentage of the sick receive inadequate medical treatment or no treatment whatever, and that many cases of serious diseases—cancer, for instance—go from onset to fatal termination without once being seen by a medical man. About 10 per cent of the total deaths of Europeans in the union from all causes are not medically certified, which means that the victims have not been seen even once by a doctor. Another great defect of the present system of medical services is the scant attention paid to the prevention of disease and the maintenance of health, either in the individual or in the community. Unless the present individualistic, competitive and purely curative system of medical services can be modified or adapted to meet modern needs and conditions it will assuredly "go under" and be replaced by some system that will meet those needs. The need is for a system which will not only bring efficient curative medicine within the reach of the sick of all classes but one under which every medical practitioner will devote special attention to the prevention of disease and the maintenance of health—in the individual and family and in the community as a whole. An obvious plan of reorganization is the nationalization of medical aid for the whole community—the provision by the state of free medical care and treatment for all citizens, or for all who wish to avail themselves of the state service. There are, however, serious drawbacks to any such plan; the elimination of salutary competition and rivalry; the loss or restriction of choice of medical attendant by patients; the "dead hand" of state control, and the shackling effects of bureaucratic administration and "red tape"; the risks of imposition and exploitation; and the difficulty of preventing rapid increase of expenditure. In most countries today the policy is to endeavor to meet the medical needs of the people by developing a system of free medical services for the indigent, and of aided medical services for those who are only able to contribute—the latter being usually provided under some scheme of national health insurance. The essential feature of most such schemes is that the insured are either encouraged or required by law to make regular and systematic contributions out of their wages or earnings; employers are also required to contribute, and a contribution is made by the state out of revenue derived from general taxation. Out of the fund so formed are paid the fees and allowances of medical practitioners and others employed in rendering services to the insured, these being usually fixed and agreed on between the government and the medical profession by a process of collective bargaining. In a few coun-

tries only a cash benefit is payable during illness, the recipients being left to make their own arrangements as regards medical treatment. The potentialities and advantages of such a scheme are obvious, especially where its scope includes the wives and families of insured persons, and the benefits comprise specialists and hospital services. Its great drawback is that, while it facilitates and provides for treatment, prevention—both in the insured and in the community—is apt to be neglected; it may even tend to increase the amount of incapacitation and illness, or, at least, the “lay-off” from work due to sickness. It does not make provision for promoting and encouraging cleanliness and healthy living, the removal of the root causes of sickness and disease, and the building up of a fit and virile community. Under the English scheme something is done in this direction by paying the medical attendant at a fixed annual rate per insured person, irrespective of his health or illness—so that the healthier the insured community the less work the medical officer will have, and it is therefore his interest to prevent disease in the insured. The essence of national health insurance is state assistance, out of revenue derived from general taxation, in meeting the medical needs of the poorer sections of the community.

SEWALL, H.: PRIVATE PRACTICE AND STATE MEDICINE, Colorado Med. 23:230 (July) 1926.

It is self-evident that no private physician or collection of physicians could rationally pretend to cope with the problems of prophylaxis on a large scale. The doctor is not trained for such work; if by chance he knows, he has not the power to enforce obedience to his advice. What is manifestly needed in this field is an impartial central authority, highly trained in the science and art of preventive medicine. Such is the ideal, often feebly imitated in municipal and state health departments, all of which are the more or less competent correspondents of our national public health service.

STATE MEDICINE—NEGATIVE

AMERICAN MEDICAL ASSOCIATION: FEDERALIZED MEDICAL TREATMENT VERSUS THE PRIVATE PRACTITIONER, editorial, J. A. M. A. 86:1840 (June 12) 1926.

By the Veterans' Act of 1924, Congress authorized hospitalization of veterans at government expense, without regard to the nature or origin of the disability. This treatment of disease at government expense was made available to all veterans in certain classes, without reference to the ability of the individual to provide treatment at his own expense or his right to obtain it from the state or city in which he lived. May 17, the House of Representatives passed a bill extending such government attentions to cover outpatient treatment as well as hospitalization, and enlarging the term "veterans" to include women who served as army nurses under contracts between April 21, 1898, and Feb. 2, 1901, contract surgeons and contract dentists. How long before the same reasoning that has provided these non-military bounties may be expected to provide similar arrangements for governmental civilian employees? And, if later the families of beneficiaries already on the rolls are placed among the elect, the step will not have gone much farther. State medicine in this obnoxious form is with us, and is tending to grow under the patronage of the federal government. Physicians and private hospitals, even now, must compete with the federal government for the practice of those whose disabilities have not originated in government service and who are abundantly able to pay for treatment. The House of Delegates has three times passed resolutions voicing its opposition to this type of state medicine. Resolutions, however, accomplish nothing unless backed up by action. That action must come from the rank and file of the physicians throughout the country, who must make known their views to their senators and representatives in Congress. Action must be prompt if the extension of free federal medical service is to be checked.

AUSTIN, M. A.: COLLECTING MEDICAL FEES, J. Indiana M. A. 23:270 (June) 1930.

Whatever we do we can rest assured that many of us are going to see state medicine an actuality. The entering wedge for this is the politicians' bid for the soldier vote. Already we have free medical, surgical and hospital care for all ex-service men and women, irrespective of their disability, and a recent survey of the government hospitals showed that 45 per cent of the patients in these hospitals are now being treated for conditions that have no connection with their service during

the war. Tuesday evening, Feb. 25, 1930, in Anderson, the American Legion held a big meeting and were addressed by Congressman Albert W. Vestal, Representative of the Eighth District of Indiana. His bid for the soldier vote was not only to see that the present free hospitalization of soldiers be continued, but that, with the building of the new hospitals as planned, and one of which will be built here in Indiana, this free hospital care will be extended to the wife and children of the ex-service man and to all his dependents, which includes, of course, his father and mother, brothers and sisters, foster-father and foster-mother, grandparents, uncles and aunts, and perhaps cousins. In addition to this, Mr. Vestal stated that he would sponsor a bill to pay the families an allowance whenever a soldier is confined in a government hospital, irrespective of the cause of his hospitalization. I have just had a man tell me that he could not pay his bill because his stepdaughter's husband had a serious case of scarlet fever and rheumatism which had disabled him for several months, and the stepdaughter, her husband and two children were being supported by my patient. Under Mr. Vestal's new law, my patient being an ex-soldier, his stepson-in-law is now his dependent and could be hospitalized in a government hospital. And if the allowance for families is put over and my patient should become ill, then he could draw an allowance for the maintenance of his wife, two stepsons, his stepdaughter and her husband and their two children, as well as his own parents, and a mother-in-law.

BELL, W. J.: STATE'S RELATION TO PRACTICE OF MEDICINE, Texas State J. Med. 26:212 (July) 1930.

What, in a broad sense, are the objectives of that activity to which we refer as preventive medicine? As an answer to this I should offer: (1) prevention of acute illness; (2) prevention of chronic ill health, and (3) prevention of premature death. If one analyzes carefully what is involved in the three headings just enumerated, the conclusion is reached that outside of preventive medicine there is little left in the whole medical field. For this reason I would be disposed to take issue with any one who would offer the suggestion that preventive medicine is the function of the state and therapeutic medicine the function of the private physician, because preventive medicine includes so much of medical treatment, whether applied to the individual or to the community, that a definite line of demarcation cannot properly be drawn. We may agree that the solution of problems in which the whole community is involved must be a function of either the state or the municipality (a subdivision of the state). In this class we might group such activities as the protection and treatment of water supplies, the safe disposal of

sewage, the control of milk supplies and campaigns such as those for the eradication of malaria and hookworm. We must agree that these activities have been markedly successful in lowering the incidence of typhoid and other water-borne and milk-borne diseases, and in lowering the incidence of malaria and hookworm. I submit that we would agree, also, that these activities, being communal activities, are essentially and of necessity initiated and carried out by the state or by the municipality. They could not readily be initiated and operated by an individual. When we come to consider prevention as applied to the individual, we enter into a field of controversy. I submit that immunization, serum or vaccine treatment of communicable disease contacts, periodic health examination, school health supervision and infant hygiene, and the clearing of foci of infection, as, for instance, diseased tonsils, are all medical services to the individual. Yet each and every service enumerated in the examples quoted is for the purpose of preventing the development of some pathologic condition. How, then, are we to determine the length to which the state may properly go in providing service to which, for the purposes of this discussion, I choose to apply the term "state medical service?" I am emphatically opposed to the adoption of any system of state medical service not fully justified by economic or other reasonable conditions. I am opposed to the introduction of any system that would tend to rob the practicing physician of initiative, of ambition and of the advantages and stimulation of competition, as a result of which he might become simply a part of a statutory bureau; a system that, further, would tend to pauperize the individual receiving such service by giving him at the expense of the state something which he might reasonably provide for himself. The state or the municipality might properly assume as its function in medical service all those activities which have to do with community groups, and that medical service, as between physician and patient, should be considered the prerogative of the private physician. In order to accept this as a basis for consideration of the subject, it will be necessary to have a clear understanding and a cooperative relationship between the medical profession and the state health organization, because point after point of conflict is bound to arise. For example, some new health activity may be introduced of which the private physician is well qualified to take charge. The public must be instructed as to this new activity, as to its desirability and as to its utility. For purposes of propaganda in this connection, the state may well at its introduction carry a much greater share of the load than it would expect to carry permanently. The state may properly take on the functions of the private physician for purposes of propaganda at the inception of a new procedure in medical service to the individual, but always with the understanding that, when the procedure has been introduced and established, the responsibility will revert from the state to the practitioner. The physician

has here an important opportunity which should not be overlooked. It is important both from the point of view of practice and from the point of view of revenue that the physician encourage the public to seek the service. In every center of population there are those who are unable to provide medical treatment at their own expense. These people must be treated, and only too frequently they impose on the humanitarian attributes of the practicing physician. The state, in this connection, is not assuming its proper responsibility; it should make provision for the medical care of those who, unfortunately, are unable to provide medical service for themselves, and in treating the poor and the indigent the medical practitioner should do so at the expense of the state or the municipality, whether the service is preventive or therapeutic in the ordinary acceptance of the terms. Another group that must be considered is the pioneer in sparsely settled areas. The state cannot refuse to recognize the rights of the settler in sparsely settled and pioneer areas to receive, in a measure at least, the advantages of modern medicine available to those resident in older and more settled areas. Some agency must assume responsibility for these population groups. Only two agencies may reasonably be considered: (1) the organized medical profession and (2) the state. Is the organized medical profession able and willing to assume this responsibility? If it is not, then can it reasonably refuse to endorse the state's assuming the responsibility for supplying medical care to these underprivileged citizens? To me it seems that while the state is the logical agency for assuming this responsibility, the responsibility itself should be discharged through the agency of the profession; that is, the state should employ the medical profession, individually and collectively, to the greatest possible extent in rendering such service as may be necessary for the area or the group in question. This, I feel, can be done by cooperation between the organized medical profession and the state authorities, and that a working policy may be determined on by which the needy citizens may receive service without imposing a load of unremunerative work on the practicing physician. I have attempted to indicate the fundamental principle that all the citizens of any state are entitled to receive a reasonable measure of modern scientific medical service. I have also tried to indicate that I do not feel that the medical profession should be imposed on in this connection. One special branch of medical service which has been assumed and operated for citizens as a whole by the state is the laboratory branch. In Ontario, under the capable administrative direction of Dr. Forbes Godfrey, minister of health for the province, we have at present a public health laboratory and seven branch laboratories located in the various health areas into which the province is divided. At each of these laboratories, service is given to the public through physicians in the routine diagnosis of communicable disease, as well as examination of miscellaneous specimens to aid physicians in the diagnosis of

the various infections. The routine examinations carried on include bacteriologic, serologic and chemical tests. Respecting state medical service, it is my feeling that the outstanding need at the moment is assistance to the citizens, through the medical profession, in more accurate and modern facilities for diagnosis, and, further, that facilities for early diagnosis must be extended if we hope to meet the situation presented in such problems as that of cancer control. It is quite beyond the resources of the private practicing physician, especially the general practitioner, and even beyond the average hospital, to install a full equipment of modern facilities for diagnosis. Further, it is not to be expected that the practicing physician, especially the busy general practitioner, will be conversant with the technic employed in these various laboratory procedures and will be able to perform the tests. Our first objective is to provide facilities for better medical service to citizens, especially in rural areas. Our second objective is to provide facilities for carrying on scientific work in medicine, so as to encourage scientifically trained medical practitioners to settle in areas where these facilities do not now exist. We suggest as a staff for the clinical laboratory center, a sufficient number of fully qualified physicians, technically trained, to head the various branches of laboratory work to be carried on, with such technical and clerical assistance as may be required. We suggest further that the housing of the center, with the complete equipment and staff, be a financial charge on the provincial government; that the initial cost of the equipment and housing be borne in part by the local community; and that the annual maintenance charges be borne by the central government. We suggest that a minimum charge be made for laboratory service rendered by the center but that such persons as may be certified by the attending physician as being unable to pay this charge be given attention without a fee. As to persons coming to the laboratory center for attention, the center will receive only those bringing with them a carefully written history signed by their attending physician, to which is attached a written requisition, also signed by the physician, indicating exactly the laboratory service desired. The laboratory service will then be rendered, and the written reports attached to the physician's written history of the case. These will then be returned to the physician by mail—not given to the patient—and on the physician will rest the responsibility of interpreting the laboratory reports, in making his diagnosis and prognosis, and of giving advice respecting treatment. In other words, the laboratory will in no way assume any direct responsibility to the patient. The laboratory will not come between physician and patient. The physician will still maintain his relationship with his patient but that relationship will be materially strengthened by the results of the laboratory investigation available to him under this system. The state may be faced in the near or more distant future with the necessity of supplying some form of state-aided medical service. I submit that the laboratory service I have referred to briefly here offers something to supply a need that is immediate.

BIGELOW, L. L.: SOCIAL AND ECONOMIC PROBLEMS AFFECTING MEDICAL PRACTICE, Ohio State M. J. 22:606 (July) 1926.

The mere investiture of a man with the degree of Doctor of Medicine does not wipe out his instinctive human revolt against injustice and exploitation. Socialize the practice of medicine, as you inevitably will under state medicine, and the best men will seek other lines of endeavor, if any there be left, where their talents and abilities, unhampered by artificial bureaucratic restrictions, may have free play and proper recognition. And then in time we may witness the deplorable spectacle of medical men striking for higher wages. They struck in Ireland for \$35 a week. Or we may find the panelized doctor making a second visit to deliver the placenta, thus earning another small fee of which there must be many, if their sum is to be sufficient to meet his monthly obligations. It has been so reported from Germany. Or we may see the American medical profession through committees of its more widely known members, soliciting their colleagues in other countries for money gifts to keep its members and their families from starvation. Have not such appeals as this come to us out of Austria? Sentimentality? I dare look you in the face and say it is sentiment and not sentimentality—sentiment that we can ill afford to exchange for the panelized, sovietized, job-lot, piece-work service of a harassed, underpaid and overworked state-medicine doctor whose first allegiance is not to his patient and his conscience, but to the boss of the gang of which he is one, whose good will he must foster to hold his political job. No one with any knowledge of the influence of mental states over bodily conditions will be disposed to deny the tremendous therapeutic power of that intimate personal relationship between doctor and patient out of which is borne confidence, respect, esteem, affection. By the extension, through the World War Veterans' Act of 1924, of the privilege of hospitalization and medical and surgical care to all veterans of all wars since 1897, no matter what may be the nature of their disabilities and without regard to their origin, nearly five million men were potentially pauperized at a single stroke. Here we have the federal government not only planting the germs of state medicine in our body politic and entering directly into competition with private practitioners and private hospitals, but embarking on a course of paternalism that is bound to foster a flabby and spineless citizenship, which may prove to be the seed of national decay. With this beginning, need it shock you that further amendments are pending that will establish a vast dispensary service for outpatients, that plans are being laid to extend this service to every dependent member of the veterans' families and that one statesman (God save the mark! His letter is on file in our Association office) feels that "this service should be given employees of the government in lieu of higher salaries, because the medical personnel has to be maintained anyhow and its

use should be made as general as possible." The Sheppard-Towner maternity bill is one of these subsidy measures by which the principle of local self-government is being undermined, and under which "the transit of baby souls from the hand of God to the bosom of society" is going to be standardized, regulated, and ultimately conducted by agents appointed by the state. Can anyone doubt that the time is far distant? The law in our own state which requires an annual census of crippled children through house to house canvass, and provides the machinery for their examination, and for the treatment of indigent cases by doctors paid by the state at rates of pay determined by the state, might be analyzed from the same point of view, and its inevitable impetus in the direction of state medicine pointed out. Compensation by the state for medical service to one class of sufferers who previously have had this service as a charity, freely and gladly rendered as a part of our contribution to the welfare of society, is subsidizing a small but important and influential group in the profession and influencing them in favor of state medicine. How about the cardiac cripple? He is responsible for about 16 per cent of our mortality rate. How long will it be before an "Ohio Society for Cardiac Cripples" is formed by a luncheon club which must have some welfare uplift outlet for its energies, and shortly thereafter a propaganda initiated to have the state take over the care of this large share of the doctor's endeavor. These movements, and others on which I have not touched, have already worked an economic hardship on the medical profession, and unless their ultimate effect on medical practice and medical progress is properly appreciated by us and by the public, and some effort made to check them, are bound to work greater hardship and final disaster. For that is what I conceive state medicine to be, and I do not see any other outcome if the present drift goes to its logical conclusion.

FINDLEY, PALMER: STATE MEDICINE, Nebraska M. J. 14:483 (Dec.) 1929.

State medicine may be defined as a system whereby all physicians are educated under state control and are salaried by the state. They are to be supported through taxation and receive no direct compensation from their patients. It is presumed that since the doctor cannot profit by the misfortunes of his patients he will be actuated by motives that are pure and undefiled. His status would be likened to that of the educator. Medical education would be controlled and directed by the state. Practice would be supervised by the state; salaries would be fixed by the state and in proportion to the responsibilities assumed and skill expended. The doctor would be assigned to definite localities, postgraduate courses would be

provided and required, vacations would be granted, and there would be pensions for physical disabilities and old age. We would have none of the overcrowding of the cities and neglect of the rural communities, for the doctors would be allocated in accordance with the needs of the communities. There would be none of the nefarious practice of fee splitting because there would be no fees to split. There would be no unnecessary services performed for reason of financial reward and patients would be referred to the doctor most competent to perform the services rather than to be retained in less competent hands. It is argued that public school education was once more bitterly opposed than is state medicine. And now we have public education and it is costing the taxpayers the tidy sum of not less than two billions of dollars annually. The proponents of state medicine affirm that it is as much the business of the state to prevent and cure diseases as it is to educate our youth; they argue that free education does not pauperize, nor will free medical service. Fifty years ago there was little supervision over medical practice. Now we have state control of licensure. We have industrial commissions. Every community has its health officers, the state provides for the care and instruction of the deaf, the dumb and the blind; the cripple, the mental defectives and the victims of venereal and contagious diseases are cared for by the state. The government as well as many private organizations are engaged in educating the public in health problems. We have adjusted ourselves to these obligations and they are generally approved by the medical profession and the public. If it is the duty of the state to provide for these exigencies, why, we are asked, should not the state provide for the acutely ill and injured; for the rich and poor alike? The public schools are open to rich and poor alike; police protection is provided and without class distinction. Why not medicine? Formerly the medical profession was solely concerned with the cure of disease; now the prevention of disease is of most vital concern, and is this not the duty of the state? Traveling clinics, at the expense of the government, are supplying medical services to the widely scattered communities in Alberta. The panel system has long been established in England and is fairly satisfactory to the profession and the public. In Germany 40,000 doctors are employed by the government and two thirds of the German population receive medical services and hospital accommodations from the state. The maximum income of a doctor so employed is \$50,000. In the Canal Zone there are no private practitioners, no cults, no quacks to prey on the credulity of the suffering public, no "patent medicine." All is under government control. Preventive medicine has made the Canal Zone one of the healthiest places in the world. In support of state medicine it is contended that most advances in medical science are made by salaried men and that this will be increasingly so in future years. In support of the contention that

state medicine is an economic necessity, it is estimated that there is an annual expenditure in the United States of \$700,000,000 for drugs, \$2,000,000,000 paid by industries for illness, \$6,000,000,000 for lives needlessly lost, \$1,200,000,000 for hospital maintenance, \$90,000,000 for funerals and only \$65,000,000 for public health. Advocates of state medicine are wont to refer to the Army and Navy Medical Corps as evidences of governmental efficiency in medical affairs. It is contended that, under state medicine, granting that the government would reward the doctors as liberally as it now does the Army and Navy Medical Corps, physicians would be better compensated than they are now in private practice. It is the specialists with larger incomes who would suffer under state control. It is predicted that state medicine would abolish quackery and secret nostrums and that it would foster research in the cause, prevention and cure of disease, and to a greater degree than is now possible under private direction. The sparsely settled portions of our country are inadequately supplied with doctors and hospitals and it will be the duty of the state to provide facilities for these outlying districts where the private practitioner could not eke out a living. There will be traveling clinics such as are now to be found in the province of Alberta. One such traveling clinic is now supported and directed by the state of North Carolina for the benefit of rural communities. Medical education is acquired at great expenditure of time, labor and money. Seven to twelve years of such sacrifices are scarcely justified in the prospect of a salaried job such as state medicine could offer. Admitting that the rank and file of the profession would be better rewarded in state medicine, there would be little incentive to make the necessary preparation for a distinguished career. Take away individuality and you destroy initiative. State medicine cannot change human nature, though it may change human relationships. Independence in medical practice is as essential to the happiness and prosperity of doctors as is independence in citizenship. There will always be independent practitioners. In the main they will be the most progressive and competent. State medicine will attract the weaker element of the profession. Those who are able to pay the price will continue to employ the private practitioner. Those who cannot pay will receive the services of the profession as they now do. Doctors are committing professional suicide in their zeal for preventive medicine and much has been accomplished to the financial loss to the profession. State medicine is in vogue today to an ever-increasing extent, but to make a universal application of it is impractical and impossible. It has proved so in European countries and it will be less applicable to individualistic America. In a word, it is paternalism in its purest form; a word that is repugnant to American democracy.

HAUSSLING, F. R.: ADDRESS AS PRESIDENT OF ACADEMY OF MEDICINE OF NORTHERN NEW JERSEY, J. M. Soc. New Jersey 27:401 (May) 1930.

Most laymen feel that their own physician is a most trustworthy individual, but, while this is undoubtedly true, my reaction after twenty-five years of practice is that they also feel that all other physicians, and the profession as a whole, bear watching and that their acts are influenced mostly by selfish motives. What is the result? The spirit of state medicine—and, believe it or not—state medicine in its broader sense has arrived. It is here. In foreign countries where it is more firmly entrenched, it has proved to be no great panacea for the ills of mankind nor has it elevated the ethical standard of the practice of medicine. After spending two years of my life abroad, I need no one to tell me this. I draw my own conclusions from personal observation and contacts. You may say the workmen's compensation law in force in New Jersey is the only law on the statute books in this state applying to state medicine, and that it has resulted in great good for the workingman by providing him with financial protection during his period of disability. The law protects the injured workingman, it protects the employee and through him the public at large, but does it protect the family physician when it permits his patient, often against the patient's will, though his physician may be perfectly competent to handle the case, to be taken out of his care? Isn't this state medicine to the nth degree—when we dictate whom a man shall have attend him when his life and health are at stake? The argument that the medical care of the workingman was neglected does not hold good. Long before this law appeared on the statute books, the workingman received excellent medical care whether or not he could pay for it. Competent family physicians and hospitals and clinics in charge of competent men, rendered good, conscientious, free medical service. They are still doing so in some hospitals that are at the same time collecting under the law for hospital care from carriers who are providing support for the injured workingman during his period of disability. When the 'spirit of state medicine is applied to individuals well able to pay for luxuries as well as necessities, and this spirit is enforced by foundations through the insidious use of wealth, I feel that it is all wrong, does not tend to increase the sum total of scientific medical knowledge nor quality of the material entering the medical profession and denies that democratic principle that all men are born free and equal. State medicine, in its broader sense, is directed not only toward health protection but also (and this fact seems often to be lost sight of) toward the material protection of laymen well able to pay, by regulating the maximum fee. It has always seemed to me that if the physician will give freely of his time and energy to those unable to pay and will

be moderate in his charges to those with limited means, then his fee to those in affluence is entirely a matter between the patient and himself; unless we grant the principle of socialism as correct and assume that under its workings we shall have no affluent class to deal with. Can science advance and a high general level of excellence be maintained in any profession if laws are enacted or usages allowed to creep in that discourage the higher grade of raw material from entering that profession or, having entered and become molded for its life work, harass it with the struggle for existence and the bare necessities of life? Granted that this is so, then surely it is not out of place here and at the present time to discuss the principles of state medicine and their far-reaching effect on the medical profession.

HOHLEN, K. S. J.: HIGH COST OF MEDICAL CARE AND STATE MEDICINE, Nebraska M. J. 15:217 (June) 1930.

The question arises: Are the physicians of this country willing that the government should take control of all health matters, a form of state medicine? Some physicians are favorably inclined to state medicine; whereas I believe the vast majority would look with great disfavor on state medicine. Are we as physicians facing this danger? Personally, I believe we are. There are indications on all sides that we are getting very close to state medicine. Let us consider the cause, or in technical medical language, the etiology that underlies all this talk of state medicine. I believe a prime cause is the fact that he does not realize that in planning for, or thinking of the future for himself or his family, that at any moment sickness or injury may befall them, and that nothing has been provided in the family budget to pay for this emergency. His education in health matters has been sadly neglected. Who is to blame? The general public seems to be totally ignorant of the old adage that "health is wealth," and seem to have substituted "automobiles, clothes and radios indicate wealth" even though most of these things are bought on the instalment plan. It used to be in the years gone by that the baby was paid for by this plan, but now the baby has to take a back seat for other luxuries and often is not paid for at all. You are all aware that the average earner's wage is usually divided so that it covers the ordinary needs of life such as groceries and the like, the instalments that are due on the furniture, fur coat, radio, or automobile; but nothing is set aside for the emergency of sickness or injury. Merchants everywhere are encouraging buying on the instalment plan, under the assumption that it is a good thing for business. And when the crisis of sickness or injury comes, there are no resources for medical care and the final act is always the bankruptcy law which gives absolution, and

the doctor is the loser. We as physicians play a larger part than we realize. Not from the fact that in general our fees are too high, because it has been indicated by some of those studying this question that the cost of medical care has not increased proportionately as much as commodities and labor. I believe that probably one of the greatest factors from the standpoint of the physician has been that he has not applied sound business principles to the practice of medicine. The honorable code of ethics and the traditions that have been handed down from the past are partially responsible for this. The physician has been negligent in making just charges and has hesitated to collect his dues, thus pauperizing his patients and making "dead beats" of them. They have thus failed to educate them to the fact that they must pay for their medical services just as well and promptly as they do for the other necessities of life. I believe the great trend and desire for every physician to become a specialist is another factor that has its influence on this question. Specialization carried to the extreme is a menace. Every young physician, after serving his internship, should serve as a general practitioner for at least five years. It would give him an insight to all phases in the practice of medicine from the economic as well as from the medical side, and incidentally also teach him the human side of the question and that common sense is of great value. After these five years, should he so desire, let him prepare himself for a specialty. Another factor that has played an important part in causing dissatisfaction in the minds of the public has been the relationship of one physician toward another. Often criticism or an unkind word has resulted in casting doubt in the patient's mind, causing him to wander from one physician to another. Related to this has been the sad spectacle of commercially minded physicians contradicting each other before the courts, especially in compensation cases, personal damage suits and will cases, which have resulted in a loss of confidence in the medical profession. The state has been negligent through its legislative bodies insofar that it did not enact proper legislation to protect its people, causing the expenditures of vast sums without results. Among examples may be cited: 1. Improper quarantine regulations, thereby spreading disease. 2. The inability to enact laws through its legislative bodies, to protect the people from quacks, cults and "patent medicines." In this respect the physician has been somewhat at fault and must share part of the blame with the state, because he has not been a good citizen. That is, he did not exercise his right to participate, in being interested in politics or legislation, in doing his duty, as every good citizen should, and exercise his franchise at the polls. Recently in conversation with medical men in Germany and Austria, I found a general dissatisfaction with the *krankenkasen* system in vogue there. Even in talking to laymen dissatisfaction was expressed and abuses cited as occurring under this form of practice. In England I understand the same condition exists.

LERRIGO, C. H.: STATE MEDICINE, J. Kansas M. Soc. 29:247 (Aug.) 1928.

I do not feel that this country is in any danger from proposals for health insurance such as is carried on in some European countries. I think we are much safer against this than we were ten years ago, I think that the reason for this safety is that in the last ten years physicians interested in both public and personal health have advanced in an enlightened attitude that considers seriously the social side of the whole question. To condemn mass immunization because of some apparent conflict with the pocketbook of an individual is courting social disaster. To recommend it as a measure that will defend the public welfare is to win the confidence of the great mass of intelligent citizens and to inspire in them the feeling that their interests are safe in the hands of the medical profession without legislative enforcement. Social workers are right in their contention that it is cheaper and better for both patient and community that disease be dealt with before it fastens on the patient: in other words, that it be prevented wherever prevention is possible. Having reached this conclusion we may be sure that in some way preventive measures will be put into effect. One has to remember that ill health is one of the major causes of poverty and that both the relief and prevention of poverty depend largely on adequate medical care. Social agencies insist that it is their business to see that this is provided. They look to the medical profession to help. It is idle to say that the physician engaged in private practice is fully able and willing to give this service of prevention. He may help, but under existing medical ethics he cannot go very far. Preventive medicine does not become effective simply because a doctor equips himself thoroughly and is prepared to give his services. There must be an intermediary. Someone must "go out into the highways and hedges and compel them to come in." The profession of medicine has nothing to fear from any agency which it can meet on equal grounds. Official public health work is directed by physicians. The people know how to deal with them and how ready they will be to have cooperation. The volunteer agencies will be found to be no less ready. Their health activities can be controlled. One should be willing to do so. This should be borne in mind, however: Cooperation has more than one side. To speak of cooperation when one has nothing more in mind than the protection of one's own interests is absurd. These social workers are as devoted to their projects as a physician is to the profession of medicine. Most of them are volunteer workers. Many put in more hours of gratuitous service than even the much abused physician. They will welcome his aid but he must meet them as a friendly adviser with a real interest in their aims. They will be quick to see his side of the matter. In almost every case they are educated people of keen per-

ception and wide sympathies. The physician has a real opportunity to guide them if he will. The way to handle the bogey of state medicine is to step out and meet it. The profession should control it, should regulate it, should keep it within its own hands, and always should it remember that "the one great outstanding problem before the medical profession today is that involved in the delivery of adequate, scientific medical service to all the people, rich and poor, at a cost which can be reasonably met by them in their respective stations of life."

MORGAN, W. G.: THE MEDICAL PROFESSION AND THE PATERNALISTIC TENDENCIES OF THE TIMES, J. A. M. A. 94:2035 (June 28) 1930.

After discussing the growth, decline and reincarnation of paternalism in government, paternalism in medicine, voluntary sickness insurance, compulsory sickness insurance, state medicine, public health movement and nongovernmental paternalistic tendencies, Morgan states that physicians are not willing to accept the view expressed by some that public health or preventive medicine has practically no limits. We are not willing to see the entire population, with the exception of the rich, taken away from the individual physician, whether he be family doctor or specialist, and turned over to the salaried physician who, by virtue of the circumstances under which he must render his service, will not be able to devote to the individual patient the careful study that is or may be required. No scheme has yet been evolved of state insurance, state medicine, or whatever it may be called, that has demonstrated unequivocally the advisability of going the limit in the matter of governmental control over individual health maintenance. Aside from efforts directed toward the conservation of the public health by agencies of government, there has grown apace another form of paternalism applied not to public health but to the health of the public, if such a turning of words is permissible. The list is long and steadily growing longer of agencies, medical, quasi-medical and plainly nonmedical, which have for their object some form of medical oversight, "guidance," "education," "social service," "psychiatric social service," "case work," and what not, all directed toward the physical, mental, moral or emotional life of parents or their children, and all under the guise of physical or mental "betterment." To what extent these agencies have followed the lead of the government, with its paternalistic monstrosities—the Volstead act and its correlated enactments, the Sheppard-Towner bill, the Newton bill and the long list of pieces of paternalistic legislation proposed or enacted—cannot be vouchsafed. After looking through the list of these agencies, one is constrained to ask what has come over

the people that makes such oversight necessary or possible. We are told that mothers have been "educated" in the care of their children until they are stamped by the multiplicity of directions, and in increasing numbers are turning the job over to the "clinic" or "center" or whatever agency may be available for shifting responsibility, while they read the latest thriller or go to the movies. A notable example of what may be called mixed paternalism, where physician and layman meet, may be found in the mental hygiene movement which has developed in this country within the last twenty years and has spread over practically the whole civilized world. One of the problems which all will doubtless agree comes within the jurisdiction of government care is the treatment and housing of the mentally diseased, this term being used without any attempt at differentiation in accordance with modern terminology. It is manifestly impracticable, even with great wealth, for the family to take care of its member who comes within the category of mental disorder. Provision of institutional care for the mentally diseased, however, is not the solution of the entire problem, and this the public has come to realize. It has long been felt that many persons have been committed to institutions for the care of mental diseases who might have been saved such a fate if more attention had been given to what is now designated mental hygiene—to the patient's familial and environmental history, and to the relationship between physical and mental health. The multiform nature of mental illness, conditioned as it may be by physical, emotional, social and other elements of the individual's environment, constitutes a problem the complexity of which calls for profound knowledge and individual contact which, it would seem, is the responsibility of the medical profession. However valuable the mental hygiene movement is, it is not difficult to foresee disastrous results that will offset much of the good accomplished in individual cases. The question may be justly raised whether it is wise to add another "complex" to the long list that has come out of our fast-moving life, and to wonder what proportion of the appalling increase in the number of mental patients in our country at the present time may be traced to too much paternalism applied through the various correlated mental hygiene agencies. Attention is called to these matters with a desire to arouse the individual members of our profession to a sense of responsibility in the concerted effort we are making to forestall further encroachments on prerogatives which, by virtue of training and experience, belong to us as private citizens, members of an honored and honorable profession, whose duty is to the community we serve in our endeavor to prevent and to cure disease. We must "see the whole" of the paternalistic tangle in which, for one reason or another, we find ourselves, and we must "look to the end."

PUSEY, W. A.: SOME TENDENCIES IN THE BUSINESS OF THE PRACTICE OF MEDICINE, *J. A. M. A.* 90:1897 (June 9) 1928.

Medicine in assuming any attitude of indifference to its business—and it is allowing itself to be put in that position—is fooling itself into thinking that physicians are not like other men. We have a right, and we must, for our own usefulness to society, consider the business of the profession by which we live. At present a self-appointed commission, with a representation of practicing physicians, who have been brought in mostly since the commission was organized, is proposing to study the whole subject of medical practice. Judging from the book of its director and spokesman, the commission is of the opinion that medical practice, as now conducted, should be wiped out and replaced by state medicine and industrial and other forms of corporate practice. Efficiency experts in philanthropy and sociology are ready to step in and give us all the advice and management that they think we need. This business of the practice of medicine is in the aggregate one of the great businesses of the country. We should not leave the consideration of a bureau to consider the economics of medicine. This is, in my opinion, a wise step. The facts in which I am particularly interested here are some of the readjustments and outgrowths in the practice of medicine. Some of these developments are: health insurance and insurance against the expense of disease; medical care by corporations of their employees; the practice of medicine by hospitals, and by pay clinics usually in connection with medical schools, and by corporations organized for the especial purpose of practicing medicine. In considering all of these new developments I have no feeling that medicine has any right to be hostile to them where they are in the interest of the public good. Some of them may not be to our liking, but when they are sound, when they are the natural outcome of social and economic causes, we cannot, if we are intelligent, to say nothing of being public spirited, oppose them. We must adjust ourselves to society's evolution. We exist for society, not society for us. But in that attitude we should give careful thought to these developments; try to see where they are sound and where they are unsound; and, in the one case, adapt our efforts to them; in the other, try to direct them into sound channels or to stop them. And the time to exercise easiest influence on them is in their beginnings. There are certain social and economic principles we should bear in mind in our judgments on these subjects. One is that the individual should do for himself as far as possible; that the state by stepping in and making one man assume the obligation of another, by doing for the other man what he should do for himself, is pursuing a course of unsound public policy. Another is that, where medical service is furnished a man as a part recompense for his labor, he has a right to a voice in

deciding how and by whom that medical service should be given. Another is that a profession should do what it can to protect itself in proper privileges that redound to the public good in its service as a social agent. Another is that, other things being equal, individualism in a profession is wholesome; the competition it involves stimulates vigor, initiative and resourcefulness in its members and benefits directly the profession, and, indirectly, society which it serves. Hospitals, and medical schools in their dispensaries, have long practiced medicine for the indigent. With this we have no quarrel, although there is dissatisfaction with the methods of operation, through failure to discriminate between patients worthy and unworthy of charity. In the last few years many of these organizations have stepped over into the practice for pay, on patients who are not charity patients. Here distinctly corporations are going into the practice of medicine, hiring doctors, farming out their services and collecting their fees. Taking it as a whole, this is a new development which medicine should view with misgivings, if not with hostility. The situation is economically unfair. Some of these institutions have gone much further and are proposing to practice medicine for pay at prices much under what the profession has found it necessary to charge. One or two of them—although I believe they have retreated from this stand—have gone so far as to undertake to tell the profession how much is the maximum that its services are worth and to take the position that no single medical service is worth more than \$200 or \$300. That is a sort of competition with and regulation by lay corporations of the practice of medicine that, I believe, should be destroyed if we are able to destroy it. In the last few years there has been an altogether new invasion of the field of medicine by laymen through institutions for periodic health examinations and to tell people how to keep well. I know of but one corporation which is in business for the sole purpose of the usual practice of medicine, but there is an institution in Chicago—the Public Health Institute—which has been in existence now for eight or ten years and which presents a new problem in the business of the practice of medicine. This is an institution incorporated not for profit, and sponsored by a group of nonmedical men, which has been set up for the purpose of furnishing medical services in a certain field at a price below that at which the medical profession can individually furnish them. In order to get its practice it has pursued a policy, continuous and extensive, of newspaper advertising. There can be no question of the motive or of the character of the men who are behind this enterprise, and that has made this particular case a much more difficult one to handle. There is one general objection to all these forms of the practice of medicine by corporations and that is the unfortunate effect on individual initiative and ambition. The lawyers have emphasized their position on this subject by having laws enacted in many states preventing corporations

from practicing law. The ground would certainly be as good for laws against the practice of medicine by corporations. How are we going to meet these developing situations? We are in the position of bystanders who would undertake more or less effectually to make the situations as satisfactory as possible. We ought not to be bystanders in this situation and we should accept no such position. What can medicine do to counteract these tendencies? The first thing, and the most important, would be to put practice back in the homes of the patients, where 90 per cent of it belongs. The essential thing to do this is to produce doctors that can, as they should, treat this 90 per cent of the illnesses that come to them. There are a few people, who are able to afford every convenience and luxury, who prefer the hospital to the home in their illnesses; but I am convinced that this is confined to that part of the population that pays income taxes, say about 4 per cent. We are not producing doctors to do general practice. That last of all things is what is needed to make sickness less expensive, to enable the patients to pay their own way, and to put practice under the control of physicians rather than of institutions. In order to be effective, our positions must be valid and not based on petty interests. What we need is to formulate a wise policy in regard to these things, to be consistently, if not aggressively, carried out. But if practice must be done by organizations, can we take a directing part in their management? The organizations which are doing this are hospitals, pay-clinics, ambulatory clinics—usually connected with medical schools—and corporations organized for the practice of medicine. Can we hope to take over an influential or directing part in these corporations? Or have we any other organizations to offer in their place? It is now the accepted policy that physicians shall not be members of the governing boards of hospitals. In my opinion, we should make it our policy to offer able and fair physicians for directors of our hospitals and try through them to obtain a direct part in the hospitals' management. Indeed, I go further in this hospital matter and believe it is good policy, for the profession and the public, that medical groups should develop their own hospitals. That hospitals for pay patients can be made self-sustaining, even under the present conditions of outside standardization, is shown by the fact that there are numerous large hospitals, under the management of physicians, literally or in fact, that are now doing it, some of them even with profit. They live without endowment and without the aid of outside charity, except for the care of indigent patients, and they are performing well the hospital service for their people. There are also many hospitals which are paying their way in the smaller places in the country that have been established and are controlled—usually owned—by physicians, who have built them because there was no one else to do it. The other active development of medical practice which is a positive contribution to the situation of medical business is the

organizations of medical men for the conduct of medical practice. Organizations of medical men somewhat after the pattern of these, which are prepared to take care of special kinds of disease or of practice in general, may be the outcome of the competition offered by pay clinics conducted by hospitals and teaching institutions, or of such institutions as the Public Health Institute of Chicago, organized for the practice of medicine. It is the introduction of combinations into the practice of medicine. The group practice clinic is the most significant development in the business of the practice of medicine. These clinics are, I believe, economically and scientifically sound. Group clinics are the chief positive contribution of physicians in the field of corporate medical practice. These organizations indicate how successfully physicians can manage not only their own especial business of practicing medicine but the business of hospitals and of institutions of research. These organizations thus far have developed chiefly in connection with surgical practice, because of the excessive prominence and pecuniary advantages of that practice, but not all of them have developed around surgeons and they are becoming more and more centers of other medical activities. Of course, the objection is always raised, against physicians running their own business in any form, that physicians are notoriously incompetent business men. Wherever one goes one finds physicians who have shown first class capacity of high order in large business. We have no less familiarity with the management of business than college professors, and that they can on occasions turn their attention successfully to large affairs is shown by most of our college presidents, who are certainly in the business of executives. In fact, some of the outstanding examples of them have been recruited from the medical profession.

REED, C. B.: STATE MEDICINE MEANS REGIMENTATION AND NULLITY; THE DANGEROUS TENDENCY OF LEGALIZED AUTHORITY TO USURP POWER IN OTHER PURSUITS IS NOW UNFORTUNATELY EVIDENT IN MEDICINE; THE CONSEQUENCES HAVE BEEN BAD ELSEWHERE; THEY WILL BE DISASTROUS IN MEDICINE, Illinois M. J. 56: 247 (Oct.) 1929.

The state cannot manage without commanding, and it will happen, therefore, where the state assumes authority that the medical profession will fall under the thumb of the politician. The dictation to the doctor by lay boards in certain medical institutions is bad enough, but such dictation becomes insufferable when exercised by self-seeking ward heelers and ruthless political organizations. Furthermore, where professional services, legal or medical, are rendered into terms of cost

instead of value, the type of such service soon becomes meager, inadequate and inefficient. The physician of courage, initiative, character and ability abandons the profession and is promptly replaced by the weakling and the time server. The most pressing problem today in medicine is to protect professional freedom against the encroachments of socialism and the state. To those who scoff at the danger of state medicine or regard it as a vain delusion which can never materialize, it is sufficient to say that state medicine in some form already exists and operates in every state in the Union!

WOODWARD, W. C.: FEDERAL, MEDICAL AND SURGICAL RELIEF FOR DISEASES AND INJURIES OF CIVIL LIFE, A. M. A. Bull. 23:55 (Feb.) 1928.

The number and scope of the bills now pending in Congress to expand the field of hospitalization, medical and surgical relief, and nursing, at the expense of the federal government, for patients suffering from diseases and injuries contracted in civil life, raise grave questions of economics, social relations and relative federal and state obligations that cannot safely be ignored. The World War Veterans' Act, 1924, now gives to every honorably discharged veteran of the Spanish-American War, the Philippine insurrection, the Boxer rebellion, and the World War, the right to hospitalization for all neuropsychiatric and tuberculous ailments and diseases, paralysis agitans, epidemic encephalitis, amebic dysentery and the loss of sight of both eyes, without regard to the origin of such ailments or diseases. It is now proposed to add to this list of diseases for which treatment at government expense may be demanded as a matter of right, even though they were contracted in civil life, leprosy and chronic constitutional diseases, such as diabetes, heart disorders, chronic stomach disorders and kidney diseases. Another bill breaks down all distinctions as to the nature of the diseases or injuries from which patients must suffer in order to be able to demand, as a matter of right, hospitalization at public expense; it simply directs the director of the Veterans' Bureau to provide hospitalization, medical treatment, nursing and all necessary care of disabled ex-service men in the World War, regardless of the origin of their respective disabilities. But lest there be any misunderstanding on the part of the director as to the extent of the service that he is to render for the relief of diseases and injuries of civil life, another bill requires the Veterans' Bureau to provide, without charge therefor, in addition to the care, treatment and appliances authorized by law, hospital, dental, medical, surgical and convalescent care and treatment, and prosthetic appliances for any veteran of any war, military occupation or military expedition, without regard to the nature or origin of the disability or disabilities of such veteran. If the federal government is to enter on a permanent

program of hospitalization, medical and surgical relief, and nursing for all diseases and injuries whatever, without reference to their nature or origin, pending legislation may possibly serve to open up that program and to carry it on until the federal service can be expanded so as to meet for all time the needs of the entire population. The service that the federal government now gives and that it proposes to enlarge is not a pension, for it has no relation to any disability arising out of the federal service, and it is not available for any veteran, no matter how badly he may be disabled, who is so situated that he cannot avail himself of the hospitalization afforded by the Veterans' Bureau. The hospitalization and treatment at federal expense under consideration is not even a form of relief for destitution, for the destitute veteran who is suffering from a disease or injury but who, because of his disability or otherwise, is unable to go to a hospital maintained by the Veterans' Bureau, cannot receive such hospitalization and treatment, whereas the rich veteran, no matter how wealthy, is entitled to hospitalization and treatment if he can enter the hospital. The hospitalization, medical and surgical service, and nursing given by the federal government for injuries not of service origin is a gift, pure and simple. It is a gift that is inequitably tendered, however, for it can be accepted only by those veterans who contract disease or incur injury in civil life and who are situated so that they can enter hospitals under the jurisdiction of the Veterans' Bureau. No other veteran need apply. If it be a socially, economically and politically sound procedure for the government to provide the necessaries of life for one group of citizens, in order to enable them to meet needs that have not even the remotest relation to any service they have ever rendered to the government and that have not arisen out of any physical or mental handicap on the part of the members of the group, why would it not be equally sound from a social, economic and political standpoint for the government to provide in the same manner for all citizens alike? If we are to have socialism, why not have it in its entirety?

OTHER METHODS OF MEDICAL CARE

ALAMEDA COUNTY (CALIF.) PLAN, J. A. M. A. 103:997 (Sept. 29) 1934.

Before any plan was adopted, the Alameda County Medical Association undertook a study to determine the best method of providing medical care for three classes of the population: (1) the indigent, (2) the individual of moderate means, and (3) those who can properly finance their medical care.

Various clinics and other institutions supplying medical care were already operating in Alameda County with little cooperation and no coordinating body. In 1917 the county board of supervisors established the Alameda County Institutions Commission for the purpose of taking entire charge of all county institutions wholly supported by county funds and designed for the care of the indigent sick.

In 1930, when the problems of medical care became more acute, another survey was made. The report of this survey recommended that all indigents be referred to clinics operated by the County Institutions Commission, or to county physicians, who were regular salaried employees on a part time basis. All pay clinics were abolished.

These changes left in the hands of the Alameda County Medical Association the problem of caring for the low income group, who in the new arrangement were left without medical care. After an extensive investigation, the association adopted the following resolution in October 1932:

Resolved, That it appears to be necessary to establish a plan whereby certain patients formerly cared for at health centers, who do not technically fall under the term "indigency" and at the same time require attention at the hands of reputable physicians, and whose care should be assumed at a fair price within the ability of the patient to pay; and be it further

Resolved, That the Alameda County Medical Association agrees to establish a list of physicians who will volunteer to accept calls for such classes of patients and to render service when called in cooperation with the established official county agencies and centralized social service, as established in Alameda County and according to such additional plans as may be adopted.

The call for volunteers to cooperate in carrying out the plan met with practically 100 per cent response from the members of the association.

Arrangements were then made for a cooperative plan by the medical association and the County Institutions Commission. Members of the medical association agreed to treat nonindigent patients privately for whatever fee they were able to pay, provided their ability to pay could be determined by the County Medical Social Service, and provided any necessary social work could be rendered by medical social workers of the clinics.

"The Social Service Department of the County Institutions Commission is responsible for contributing the following types of assistance to physicians participating in the Plan:

- "(a) Social study (economic situation, home and work environment, habits and attitudes of patients and family which may have a bearing upon the medical problem).
- "(b) Medical Social Case Work (aiding the patient or his family to meet social problems related to his illness, and mobilizing the resources of the community to make possible the carrying out of medical treatment).
- "(c) Determination of the patient's ability to pay for medical care. The Social Worker's chief contributions here are:
 - (1) Securing adequate data regarding financial status of patient and family.
 - (2) Evaluating this in terms of the social and medical need of the patient.
 - (3) Assisting patient and family to develop an attitude of willingness to pay for medical care, and aiding them to develop resources for payment within their means.
 - (4) Securing relevant information from other agencies who have known the patients.

Recommendations as to fees patients can pay naturally become a by-product of the above investigation.

"The Medical Worker has the following relationship to any business agency established for the purpose of credit rating:

- "(a) She can give a professional opinion as to the patient's financial resources, and his attitude of cooperation with the physician.
- "(b) She cannot take the place of the credit agency in investigation of the patient's past records as to credit rating, and the risks involved in extending credit to him."

When a call for service is made at any of the county institutions, the social service department ascertains whether the patient is already receiving relief and, if so, or if known to be indigent, the patient is referred to county physicians.

"If the patient's financial status is unknown or if he is known to be able to pay something for a home visit, the worker explains that a private physician will be sent and that the physician will discuss with him the matter of payment.

"The worker then refers the call by telephone to the next physician on the rotating list, giving him the data for Section A and B of Form 2538. She stamps the date on the physician's card and places the card at the end of the list. She records this call on the 'Report of Patients Referred to Private Physicians.' In case the first physician called cannot go, she continues down the list until she finds a physician who can make the call."

The physician makes at least one visit and renders the necessary service regardless of the patient's ability to pay any part of his fee. He then fills out a form giving certain social information and sends this to the social service department, which

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notifies the local clinic if a social investigator is requested by the physician.

Part-pay patients are referred to private physicians only after their financial status is known, and in accordance with the following procedure:

1. The social worker who has investigated the patient secures the name of the next physician on the list from the worker in that agency who keeps the list. The latter is responsible for stamping the date on the physician's card and records the referral on the "Report of Patients Referred to Private Physicians."
2. The social worker discusses with the patient the matter of payment and an understanding of the amount to be paid is arrived at before the case is referred to the private physician. The patient is also told that he will be expected to pay cash.
3. The social worker secures from the patient the signed consent for transfer of information and files this with the social face sheet.
4. She communicates with the private physician and arranges an appointment for the patient.
5. The patient is given a Refer Slip signed by the worker, on which is recorded the name and address of the physician and the date and hour of the appointment.
6. The social worker is responsible for sending to the physician any medical or social data, contained in the clinic records, which might be helpful to him in treating the patient.
7. The case is then closed at the clinic for that complaint, and considered a private patient until such time as the physician may refer it back, or until some other medical condition arises for which the patient cannot afford private care.

It is understood that the physician may request and receive assistance from the clinic social worker at any time.

Full pay patients are referred to the Secretary of the Alameda County Medical Association, for names of physicians from her own list.

During the year 1933, 2,077 referrals to private physicians were made by social workers, clerks, nurses, doctors and others in the Alameda County agencies. These referrals were made to the three groups of physicians listed in table 1: (a) those who were members of the Alameda County Medical Association and had agreed to take patients at reduced fees; (b) those who were not members of the Alameda County Medical Association and whose names, therefore, were not on the list; (c) referrals made to the secretary of the Alameda County Medical Association with the understanding that the patients could pay a full fee.

TABLE 1.—*Distribution of Referrals, for Medical Services Under the Alameda County Plan, Made to Physicians in the County in 1933*

	Number Per Cent	
Total Referrals.....	2,077	100.0
To County Medical Association.....	1,898	91.3
	Number Per Cent	
To Co. Med. Asso.....	1,898	100
For Part-pay care.....	1,812	95
For Full-pay care.....	56	5
To Physicians not on list.....	158	6.5
To Physicians, names not given.....	51	2.2

Of the total number of referrals made, 1,898, or 91.3 per cent, were made to physicians of the Alameda County Medical Association; only 158, or 6.5 per cent, were made to physicians not on the list; the remaining 2.2 per cent of the referrals were to physicians whose names were not stated but who might possibly have been members of the Association.

Of the 1,898 referred to the medical association, 95 per cent, or 1,812 referrals, were for part-pay medical care, and 5 per cent, or 56 referrals, were for full-pay medical care.

The following study has been made of the results of the first year's referrals:

Questionnaires were sent, March 1, 1934, to the 400 physicians whose names were on the part-pay lists and who were members of the Alameda County Medical Association. Information was requested on only the 1,812 cases referred for part-pay care.

Returns were received from 279 doctors, or 70 per cent of the number to whom questionnaires were sent. These returns gave information about 1,304 referrals, or 71.96 per cent of the referrals about whom information was desired.

TABLE 2.—*Patients Actually Seen*

	Number	Per Cent
Total number about whom information has been received.....	1,304	100
Patients seen by doctor.....	969	74.3
Patients not seen.....	335	25.7

The table shows that, of the 1,304 patients about whom some information was received, 969, or 74.3 per cent, were actually seen by various physicians, and 335, or 25.7 per cent, were not seen by the doctors to whom they had been referred.

Of the 969 patients seen, table 3 shows the percentage and the number of patients who paid no fees.

TABLE 3.—*Number of Patients Paying Fees*

	Number	Per Cent
Total number of patients seen.....	969	100
Patients pay fees.....	736	76.
Patients paying nothing in fees.....	233	24.

It can be seen from this table that 76 per cent of the patients actually seen paid something for their medical services, while only 24 per cent paid nothing. A complete study of the amounts received from these 736 patients has not yet been made, but the total is slightly over \$5,000.

DODD, S. C.: HEALTH ON HORSEBACK IN LEBANON, Survey Graphic 16:405 (Jan.) 1930.

In twelve villages in the Lebanon Valley 600 families now have health insurance. Six hundred families means around 6,000 individuals, since in the patriarchal joint family system the average family is large. Two hundred families pay two Turkish gold pounds (about nine dollars) each a year, 200 pay one gold pound, 100 pay half a gold pound, and 100 are included free. The amount to be paid by each family is determined neither by the size of the family nor by the frequency of sickness it has had in the past but by the ability to pay. Each is assessed according to the number of mulberry trees, cattle or other sources of income he possesses. The village meets in caucus and then the elders draw up the neatly hand-written list in Arabic script informing the physician how the village will collect its share of his annual stipend. Generally, no difficulty is met in collecting the amount, because it is less than former doctors' fees. Public opinion strongly sanctions payment. This kind of insurance works in a community in which insurance by the government or by a company is unknown and would make no headway. It comprises personal elements of confidence and individual advice and group education which no large organized insurance project can hope to include to such a degree. Under such a prospect, practice in rural regions, which is now avoided by young medical school graduates, might acquire a new dignity.

EMBREE, E. R.: HOW THE FOUNDATIONS FIGHT DISEASE, Survey Graphic 16:413 (Jan.) 1930.

Embree describes some of the notable efforts which have been put forth by American foundations during the past quarter of a century in the battle against disease. Varying methods and differing objectives have been adopted by the several boards. The Rockefeller attack has been chiefly against the great contagions, and its method has been to work exclusively with government. The Rosenwald interest is chiefly in applying modern economics to medical service and in lending a hand to the Negro as he strives for better health. The Milbank Fund is studying and testing old and new forms of health administration under the varying conditions of three types of communities. The Duke Endowment has set itself to the task of building up an adequate hospital system for all classes of the population on a state-wide basis. The Commonwealth Fund is courageous enough to attempt a drive in behalf of mental hygiene. All these foundations are taking a direct interest in the activities of the Committee on the Cost of Medical Care. The funda-

mental studies of this national committee should throw new light on the work which these boards have done and will continue to do in promoting the health and healing of the nations.

EMERSON, HAVEN: HEALTH—THE BUSINESS OF EACH OF US, Survey Graphic 16:373 (Jan.) 1930.

The perfect alibi will never be found for health. However loudly we shout public health from the housetops, it is our own personal health that we are concerned with, and we can no more attain it by hiring a health officer or by buying Christmas seals than we can heal a broken bone by proxy, or engage a civil service superintendent of hospitals to have our attack of appendicitis for us. Health is quite as much a social as a personal necessity, and if this is admitted, there is no dodging the individual and collective privilege and hence duty of attaining as much of it as the medical and social sciences have to offer us. Voluntary joint action has hardly been tried, and yet it would seem to offer great rewards in a way quite as promising in medical care as the cooperative production and purchase of necessities has proved to be under the Rochedale system. With probably at least 90 per cent of the sickness among city and rural people of the United States from causes quite out of the scope of organized official and volunteer health agencies, it is distinctly the job of the family man and his wife, the butcher, the baker and the candlestick-maker to give at least as much thought to the quantity and quality of medical care they purchase as they give to schooling and clothing today.

FISHBEIN, MORRIS: SOCIALIZATION AND PATERNALISM IN MEDICAL PRACTICE, J. Michigan M. Soc. 26:491 (Aug.) 1927.

Fishbein discusses the beginnings of medicine, the middle ages and supernaturalism, the *vis medicatrix naturae*, preventive medicine and lowered death rates, community hygiene and sanitation, degenerative diseases, medical treatment of various social classes, health insurance in Germany and Great Britain, the curse of philanthropy, periodic examination and corporation practice, venereal diseases and the corporation, group practice, contract practice, and the physician of the future. In the section headed "criticism of the individual!" he says: Practicing physicians are not infrequently criticized by public health officers, welfare workers, publicists and others because of their alleged neglect of antismallpox vaccination, antityphoid vaccination, antidiphtheria inoculation and other practices calculated to prevent disease. The accusation is a challenge to the medical profession. The value of the measures

has been established beyond any doubt. The physician must do this duty to his public in caring for their needs, or the public will get them cared for in some other manner. However, the general practitioner should not accept the full responsibility for all these sins of omission. Many of those who now criticize have for some years been "educating" the public to the belief that the public health clinics, health centers, voluntary health bodies and what not were anxious to render these services "free" to rich and poor alike and that "free" meant both the cost of materials and medical service. Is it not logical to charge part of the disturbing conditions to the error in "education" of the public; to the inadequacy of the free service and materials; to indifference? The physician must pay license fees, federal, state, county, municipal and other taxes, must spend thousands for essential equipment and transportation facilities, must serve free the poor among his clients, and must live as other citizens. How can he be expected to compete with "free" service? Formerly, protective inoculations and similar forms of medical practice were a responsibility of the physician to his patients, with government and other charity-serving organizations looking after the poor. Although most of the controllable infections were among the poor, organizations, government and otherwise, decided to extend their charity to all alike. Some now criticize physicians because many of them discontinued the practice of preventive medicine in the face of such competition. The intrusions and interferences, not of physicians' choosing, are being forced increasingly on the public and physicians by the unwarranted attempts at expansion of government into phases of personal health. The practice of medicine has changed with the increase of knowledge that has come in the past twenty-five years. The young man entering medicine today represents an investment of from six to eight years of time during which he not only sacrifices the money he spends in securing an education but also the money he might have earned and the income from both of these sums, an amount calculated to be from \$12,000 to \$15,000. In return for this, he has been enabled to look forward to a leading position in the social scheme, with the possibility that after several additional years of toiling and striving he may be able to make a fair living. What if he is to look forward to a salaried position yielding from \$250 to \$400 a month in a large organization in which he automatically follows a narrow routine? He is no longer a physician; he is no longer treating human beings for the relief of their ailments. He has become a tonsil mechanic, an adjustor of adenoids, or an inspector of gonorrhoea. The prospect is not likely to appeal to the type of man who now becomes a physician; it would not attract even a chiropractor or a Christian science healer. What, then, of state medicine? State medicine might indeed provide a standardized diagnosis and treatment for a standardized citizen. If medicine were

chiropractic, state medicine would be quite compatible with its practice; but state medicine is the death of initiative, of humanity, of science. Until we become a nation of robots with interlocking, replaceable and standardized parts, there will be little chance of such completely standardized physicians.

HARPER'S MAGAZINE: A PATIENT LOOKS AT DOCTORS
(anonymous), Harper's Magazine 161:710 (Nov.) 1930.

The extensive development of modern medical science has made certain types of specialization necessary, and no intelligent layman, even while suspecting that its overemphasis may not be due entirely to scientific zeal, fails to appreciate the greater skill and accuracy it insures. Nor does it matter particularly that the sentiments surrounding the relationship with the friendly practitioner of the past should be summoned in behalf of an increasingly impersonalized system of practice to which they have no actual relation. What matters is the fact that, in spite of the natural predisposition to confidence in the doctor and in spite of the general recognition of the altogether miraculous advances in modern medical skill and knowledge, there is obvious everywhere a growing sense of irritation on the part of the public generally toward present medical practice. Though still somewhat vague and inarticulate, it is already reflected in the increasingly defensive attitude of the profession toward the public, an attitude most marked in the discussions at the last annual session of the American Medical Association. This dissatisfaction and disillusion on the part of the layman is unfortunately not to be measured by any statistical evidence, but it is obvious wherever two or three are gathered together and the conversation turns to medical experience. Undoubtedly the growing tenuousness in the relationship between patient and doctor—which medical specialization and the growth of great, unindigenous city populations have brought about—is partially responsible. There is little opportunity for doctor and patient to sit down quietly and talk out their respective problems. While medical science has been striding ahead in seven-league boots, medical organization has failed both economically and physically to adjust itself to the changed conditions of modern life; it has failed to educate the public in either its rights or its duties in relation to the medical profession, and medical ethics are still jogging in a phaeton along a country road, with a social outlook born of the amenities of two village competitors. For the family doctor is no longer a general solution, and organized medicine has failed to provide an adequate successor. The emergency clinic is no answer to the needs of persons who neither want nor are properly qualified to receive charitable care. Nor is the medical directory in the hands of a stricken layman of any assistance. To assume that any medical graduate

is equal to any medical situation is to invite possible disaster. In short, the ever-growing dissatisfaction of the modern layman with the whole machinery of modern medicine has arisen not only out of the failure of the American medical profession to bring to the problem of doctor and patient that scientific disinterestedness which has so advanced medical science in laboratory, hospital, and clinic, but also from the lack of ordinary common sense in organizing this relationship.

HOLBROOK, A. T.: HOSPITALS AND THE COST OF MEDICAL CARE, *J. A. M. A.* 94:903 (March 29) 1930.

Holbrook states that of all patients that come to the general practitioner, including the rich, the poor and those of moderate means, less than 10 per cent require hospital care, and of the 10 per cent many are referred to some specialist. It is evident, therefore, that the concern of the general practitioner with the cost of medical care in hospitals is very limited. Consequently, the author considers the problem more in its general aspects, but, in an endeavor not to diverge from the specific topic, suggests possible relationships of these aspects to the hospital. For the purposes of this discussion he omits any consideration of fixed factors in the problem which seem to be more or less impossible of change, and confines himself to such factors as apparently present possibilities of modification. He also omits a consideration of the cost of care of the rich and of the poor. The factors considered are: (1) the traditional opposition to the discussion of the so-called commercial aspects of medical practice, (2) the traditional custom of charging fixed medical fees, (3) the lack of available economical nursing service, (4) the inconsiderate hospitalization of patients, and (5) the unnecessary consultation of specialists. In conclusion he challenges the frequently expressed belief that nothing will solve the problem of the cost of medical care but some deep, basic change and expresses a conviction that the present wide and frank discussion will bring about a better understanding and a satisfactory adjustment of fees, nursing, hospitalization and a multitude of other elements, and that prominent as a factor in the solution will be a new appraisal and recognition of the general practitioner.

LANGSTROTH, LOVELL: PATIENTS CRY FOR IT, *Survey Graphic* 16:384 (Jan.) 1930.

This "it" the patients cry for is a will to continue in certain fixed habits of mind, a will to be sick and to be cured in the ancient and commonly accepted manner, a will to be a member

of the herd and to follow herd traditions. In this sense it is an inheritance from the past, a relic of the days when disease was due to a demon who could be exorcised. For patients are still bound and satisfied by the idea that complete responsibility for disease lies entirely outside the self, just as though it was a malevolent power lurking around a corner and ready to attack and destroy. A common sense view recognizes that man's living habits are perhaps the most important items in his health; that fresh fruit, fresh milk, fresh eggs, fresh vegetables, fresh green salads and a moderate amount of meat should form the basis of his diet; that most nervousness is due to unconscious conflict which can now be successfully treated; that physical training is a necessary part of existence, and that sunshine protects against infections. It keeps down the cost of medical care by maintaining good health. But it recognizes that roentgen-ray machines, metabolism apparatus, and electrocardiographs may be of incalculable value at times, that honest surgery often cures disease and saves lives. The modern physician is working toward the elimination of his own species, though this consummation may be expected in the millennium just as the tangent touches the straight line in infinity. There is a growing expectation on his part that the layman will come to accept a greater responsibility for his own individual health. But this is answered on the part of the layman by a growing insistence that the physician will wisely sift the scientific wheat from the chaff.

LOCKHART, LEONARD P.: INDUSTRIALIZED MAN AND HIS BACKGROUND, *Lancet* 1:826 (April 21) 1934.

Every year about 50 per cent of the insured population are sick for an average of very nearly four weeks each, resulting in the loss of over half a million years of working time. This excludes the first three days of absence and it takes no account of loss sustained by those who remain at work and yet are relatively unwell and below normal efficiency. Unfortunately there is no large scale analysis of the certified diagnoses and one is therefore driven back not to analyze official figures but rather to consider what is meant by the labels attached to patients for certification purposes. My thesis is that since the law requires diagnoses limited to one or two words it gets what it demands, but that these stereotyped descriptions of highly complicated processes are with few exceptions valueless to the student of social problems. The investigations of the Industrial Health Research Board have shown that the amount of sick absence in any organization is affected profoundly by conditions not of physical but of emotional environment. Apart from seasonal epidemics, sick absence varies not so much with occupation as with places of employment. It may vary within

wide limits from as low as two days per person per annum to as high as fifteen. The variations are such that firm A and firm B in the same town, engaged in the same type of work and in other ways more or less comparable, may present figures more or less steady year by year and yet differing widely between A and B. Large annual variations within a given group are rare but between groups they are common. These rates may, and indeed do, bear little or no relation to those of the general population surrounding them. If one searches for a factor to correlate with the rates of sick absence, one finds a significant one in labor turnover, and it appears as definite that a high sickness rate and a high labor turnover go together. Sickness varies too according to the system of incentives incorporated in the payment of wages. It is generally higher for staff employees than for those "on the clock." It goes up along with the accident rate when overtime is worked consistently for long periods. Does malingering play an important rôle in producing and prolonging absence from work? Except as an odd case in special circumstances I cannot see what incentive there can possibly be for any one willingly to forego wages for sickness benefit and risk in addition the possible loss of his or her job. When the time comes for sickness benefit to fall to the level of disablement benefit a large proportion of persons "sign off" and return to work, but that can be better explained along other lines. I suggest two explanations, which will cover nearly all such cases. In the first place the patients who make this sudden decision to return to work at the end of twenty-six weeks are almost invariably cases of frank psychoneurosis or of organic disease or trauma which has passed into a psychoneurotic phase.

LOEWY-HATTENDORF, E.: PHYSICIANS AND THEIR DEPENDENCE ON POLITICS, *Med. Klin.* 26:39 (Jan. 3) 1930.

The author deplors that, because of the influence of politics, medical discoveries and the work of physicians is hampered by the opinions of laymen and constantly influenced by governmental rules and regulations. He points out that today the physician can take hardly any medical measure in the privacy of the consultation without having to consider legal, governmental or economic conditions. This state of affairs, although especially marked in Germany, is now found to some extent in nearly every civilized country. The author directs attention to France, where physicians have been making a last attempt to preserve their old liberty of action. Many German physicians had expected that the reform of the federal insurance system would give some considerations to the physician's problems. However, not much has been accomplished, and the right to the free choice of a physician, which the medical pro-

fession had demanded, still remains a Utopia. The author further relates an instance of political intrigue which, some think, proves the involvement of social insurance and politics. However, he thinks that not only insurance physicians but also the private practitioner and other free professions and likewise business people are involved in politics.

SAN DIEGO CENTRAL CLINIC SERVICE,* J. A. M. A. 103:923
(Sept. 22) 1934.

The Central Clinic Service of San Diego originated with a suggestion from the Health Council of the Community Welfare Council. The objective was to provide an organized method of meeting the medical needs of the resident indigents and others whose incomes would permit either a part or full pay service. The Central Clinic Committee is composed of representatives of the county medical society, the community welfare council, the county and city health departments, county hospital advisory board, health and development department of the city schools, navy relief, Mercy Hospital and San Diego Hospital. An executive secretary and staff operate under the supervision of the board of directors. The principal functions of this executive staff are to conduct a social service investigation to determine resources and fees to be charged and to direct patients to the physician of their choice or, if no choice exists, to a list of physicians in alphabetical order.

Patients come to the Central Clinic Service from four main sources, the physician, hospital, clinic or by direct application of the patient himself. By far the most important source is the physician, as is shown by table 1, covering the year 1933 and first six months of 1934.

TABLE 1.—*Sources from Which Patients Came to Clinic*
Year 1933

	Number	Per Cent
Referred by physicians	541	40.7
Referred by self	219	15.4
Referred by county	247	18
Referred by Mercy Hospital.....	87	6.3
Referred by San Diego Hospital.....	20	1.3
Referred by school clinic.....	103	7.6
Referred by other agencies.....	133	9.8
<i>Jan. 1, 1934, to June 30, 1934</i>		
Referred by physicians	328	50.7
Referred by self	106	16
Referred by county	68	10.3
Referred by Mercy Hospital.....	26	3.9
Referred by San Diego Hospital.....	5	0.7
Referred by school	68	10.3
Referred by other agencies.....	54	8.2

* Information on which this article is based is obtained from the Bulletin of the San Diego County Medical Society (Jan. 19, 1934) and from material furnished by the executive secretary of the clinic.

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There has been a continuous growth in the work of the clinics and in the proportion of families that are able to pay full or part fees.

The fees collected in 1933 amounted to \$22,850.39. In the first six months of 1934 they were \$18,888.56. The character of the population served is shown by the fact that, of 794 families given reduced fees in 1933, 448, or 56.4 per cent, were earning regular wages of some amount. The distribution of these wages is given in table 2.

TABLE 2.—*Distribution of Wages*

241, or 53.8%, of this group and 30.4% of the total number of families	earned below \$75 monthly
140, or 31.3%, of this group and 17.6% of the total number of families	earned between \$75 and \$110 monthly
32, or 7.1%, of this group and 4% of the total number of families	earned between \$110 and \$125 monthly
10, or 2.2%, of this group and 1.3% of the total number of families	earned between \$125 and \$130 monthly
25, or 5.6%, of this group and 3.1% of the total number of families	earned between \$130 and \$135 monthly

Of the 794 families, 346 earned irregular wages or had other sources of income such as compensation, commission, pensions, or were unemployed. These were distributed as in table 3.

TABLE 3.—*Income of Families Given Reduced Fees*

129, or 37.3%, of this group or 16.2% of the total number of families	were unemployed
122, or 35.3%, of this group or 15.4% of the total number of families	earned irregular wages
16, or 4.6%, of this group or 2% of the total number of families	had compensations
31, or 8.9%, of this group or 3.9% of the total number of families	earned commissions
48, or 13.9%, of this group or 6% of the total number of families	had pensions

There are 182 physicians in the San Diego County Medical Society who agreed in January 1933 to take Central Clinic Service patients.

"As much time as we know must be spent by all families in 'making ends meet' it has been surprising to learn how few of them have actually figured medical costs into monthly or annual budgets.

"One of the important factors in the work of the Central Clinic Service has been to analyze expenditures with heads of families, to make suggestions and to plan monthly allotments, for medical service. It has been gratifying to find that this service is successful and that families have profited by the experience.

“‘Steering’ patients is one of the real jobs of the Central Clinic Service. The 20 per cent of patients sent to physicians at full fee were not all bargain hunters who came to the agency seeking lowered fees. Many of them were persons who were at a loss how to arrange for adequate care. The explanations of the parts played by diagnostic and treatment service of the laboratories, x-ray departments, specialties of all kinds has been important. Interpretation of the social situation of the patient to the physician undertaking the treatment has been equally important.

“Many cases have been undertaken as Central Clinic Service cases only to find that, once the service has been arranged, the patients can make their own further plans. Having assurance that costs could be controlled if necessary has been a factor in the patients’ undertaking diagnostic or treatment procedures.

“Gratitude to the referring physician and to the whole service has been the outstanding point of view of patients and their families.

“The chance to have the service of the family physician or the specialists within fees that they can pay has given many patients real gratification. It has meant that the values of the patient-physician relationship have been preserved, that medical service of the finest type has been available to all members of this community.

“If social problems arise, the patients are referred to social agencies which can assist or advice is given by the Central Clinic Service workers. Cooperation between agencies has been a policy always observed.

“Each case is approached from the point of view of the family in relation to the present medical problem. The record kept is a modification of the usual medical-social face-sheet used in most case work practice. The patient shares in making the plan, he examines his own resources and those of his family. Both assets and liabilities, social and financial, are considered, situations are faced frankly. Relatives who can assist are asked to do so. But patients are taken into the plan and the success depends on the skill of the social worker in establishing in the patient the sense that he is making his budget and at his own standard of living.

“Policies regarding eligibility for reduced fees are based necessarily on the medical service involved. A family which would not be given reduced fees for minor dental service might be eligible for major surgery.

“Life insurance is generally considered an asset. However, if the family is overinsured on the general family budget the cashing of some policies is encouraged. This is true, too, if the family is obviously letting present needs suffer to save for the indefinite demands of the future.”

“The owning of homes or the buying of moderately priced homes does not in any case exclude patients from the service.

The purchase or retention of property for income or speculation, however, places the family in another category.

"The owning of automobiles does not exclude from service, but the purchase of expensive cars or luxuries in furniture and household equipment does.

"Reduction of fees is on a sliding scale and these above-mentioned factors are all taken into consideration.

"Patients are quick to recognize that the purpose of the Central Clinic Service is to give them adequate medical service and the cooperation of the majority of the families is splendid.

"The year shows that the applicants are made up of sincere persons, occasionally misguided, occasionally querulous, as a result of ill health or poverty, but eager for the most part, to be self dependent.

"The plan of fee setting for cases requiring hospitalization has been to use the part-pay hospital fee as a basis for the surgeons' fee and to pay the anesthetist and assistant in proportion.

"The original plan of fees outlined in Dr. Hall Holder's study of Central Clinic Service published in February 1933 is in use now. The basic surgical fee to hospitals is \$3.50 per day including operating room service, routine medicines, and a minimum supply of dressings. Four-bed wards are used except in those cases where a private room is considered necessary by the physician. Private-duty nursing has been on the same basis.

"Nursing service has been limited to a few days or nights and patients, for the most part, have accepted that the physician's judgment shall determine the type of nursing service required.

"It has been almost a universal experience that if requests are made for special services, not medically necessary, the patients are not within the part-pay group.

"Part of the work of the Central Clinic Service is to plan the surgical service with the patients, outlining the facilities involved, explaining and interpreting those necessary for the welfare of the patients. This is an important and detailed social service function.

"The secretary and the board of directors cannot speak too highly of the attitude of all cooperating agencies. The Central Clinic Service average of twelve hundred telephone calls a month bespeaks the constant relationship of the service with physicians, hospitals, druggists, ambulance service, and nursing service in working out the individual cases.

"Both the executive-secretary and the field worker are members of the American Association of Social Workers and are 'registered social workers' under the standards recently adopted by the California Conference of Society Work."

The reception of the plan by the community may be judged to some extent from the following editorial in the San Diego Union, Aug. 20, 1934:

"San Diego County's medical society undertook a new experiment in cooperating with its members' clientele some eighteen months ago when it established the Central Clinic. Now, after an extremely encouraging beginning, the society asks local employers to help extend the service.

"As many readers will recall from published reports, the Clinic was designed to meet the need of persons who wished to pay their way but who could not carry the full cost of medical or surgical treatment. To solve this problem an office was established under a competent social worker who was responsible for fixing the amount that any particular applicant could pay. On their part approximately 65 per cent of the Society's members agreed to abide by the decision of the central office.

"The experiment is a success. It has been widely discussed and, we are informed, has been copied in other communities. Viewed from the layman's point of view, this success is understandable. Obviously the physicians made a real sacrifice when they surrendered some of their freedom of action by accepting the aid of a third party in arriving at an equitable fee in any given instance.

"This sacrifice should win them a sympathetic hearing in calling upon local employers to cooperate by either making loans to their employees against future wages or by working out some other means of spreading the cost of emergency treatment over a considerable period.

"All parties admit that the cost of medical care is sometimes prohibitively high. We congratulate the physicians in attacking this problem locally. And we believe that they have made sufficient progress to justify their request that business concerns help broaden the Clinic's usefulness."

SMITH, J. M.: GROUP INSURANCE ENDOWMENTS SUGGESTED TO SOLVE MIDDLE CLASS PROBLEM, Hosp. Management 29:58 (June 15) 1930.

The best hospital service rendered twenty-five years ago would be smiled at today because it would be almost totally inadequate. Then the x-rays were not regarded seriously and had been installed in only a few of the more venturesome hospitals. Pathology was the only thoroughly established laboratory branch and it was on a much simpler scale than today. Electrical analysis, radium, nitrous oxide and oxygen anesthesia, biologic products, highly specialized operating room equipment and service, physical therapy, dietetics, record libraries, social service and occupational therapy with their corps of specialists and technicians have added large items of expense that were unknown a few years ago. Today all patients, poor and rich, must have the benefit of these requirements of modern medicine. The clinician cannot do good work without them.

Twenty-five years ago there was one nurse to six patients, while today the average is one nurse to two patients. The ratio of hospital personnel is now $1\frac{1}{2}$ to each patient, while formerly it was only one-half to each patient. The conclusions are that hospital care has in every way kept up with the requirements of modern medicine, the cost of care to the hospital has doubled in fifteen years, and the cost of care to the patient has increased only 50 per cent. A way to reduce the cost of private patient care to the person in modest circumstances is by endowments and gifts for that purpose. The study of group health and accident insurance is suggested.

STREETER, C. P.: PIONEERS PLOUGH A WAY, Survey Graphic 16:402 (Jan.) 1930.

According to Streeter, in Saskatchewan, pioneer farmers have found a plan whereby families of moderate means can pay their doctor and hospital bills without worrying about "the high cost of sickness." For there the cost isn't high. Ten dollars a year pays the farm family's doctor bill. Twelve dollars settles the hospital account. There is no extra charge when babies are born. And yet doctors make more money than the average country physicians, and hospitals have no deficits! The plan developed unexpectedly eight years ago when the rural municipality of Hillsburgh, in western Saskatchewan, found itself without a doctor. Crops had been poor, collections worse and the winter unusually long and severe. The doctor had gone to southern California in search of a steadier income and a warmer climate. In this predicament, the municipal council learned that a young physician on the staff of a large hospital in British Columbia would consider locating in Hillsburgh, if he could be assured a living. The result of their negotiations was a contract which stipulated that the rural municipality would pay the doctor a salary of \$4,500 a year in return for free treatment of all sicknesses, including maternity cases. The patients, however, would pay for hospital care, operations, specialists and medicines. Money to pay the doctor's salary comes from the general tax fund, resulting in a tax increase of about \$10 a year for the average half section farm, or \$3.33 per capita (of which, it happens, eighty cents is paid by absentee landlords). Medical service costs the village folk approximately the same amount per capita. When they have paid this small tax, however, they have bought the doctor's services for the year unless operations or specialists are needed.

WALLENTINE, N. R.: INDUSTRIAL MEDICINE, *Northwest Med.* 25:317 (June) 1926.

Wallentine states that the leaders in the medical profession, whether engaged in industrial practice or otherwise, recognize the deficiencies of the medical service furnished, as a rule, to the working man and woman in industrial communities of the land. They have devoted much thought to the correction of these conditions. Community health centers, where preventive measures applicable to both the home and the working place, will be installed, where diagnostic dispensaries will afford complete physical examination to all in the community, where properly equipped hospitals will meet every need for the most advanced scientific care of the sick and the injured, where all the physicians furnishing this service will be paid a regular, just fee. This will be, in the judgment of most leaders, the final solution of this need. This idea necessarily incorporates with it some form of health insurance which must be worked out by some one. If physicians leave it to the politicians or laymen they will regret it. If they prepare themselves adequately by a study of health insurance and state medicine in foreign countries, they will find those countries in which the profession more or less has organized the scheme, to have the most beneficial and most workable plans. Industrial medicine and surgery in its most comprehensive form represents the halfway house between the old individualistic form of the practice of medicine and the future community health and medical service. The future of industrial medicine and surgery in the United States, therefore, is more intimately related to the great medical economic problems confronting the entire profession than any other specialty. The solution of these problems will revolutionize the practice of medicine in this country within the next decade. The solution need not be in form of health insurance, as conceived today, nor need it include any of the objectionable features of state medicine or other forms of compulsory medical service, but rather, by a constructive program on the part of the entire medical profession, a solution will be found which will eliminate the wasteful practices of the day and will make available to all that service which will prevent disease, will give the best hospital, medical and surgical care, will vocationally train the handicapped when necessary and will conserve and reclaim the nation's man power.

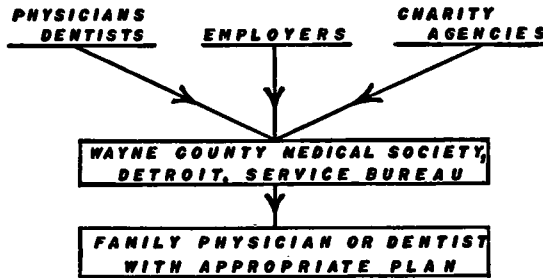
THE WAYNE COUNTY MEDICAL SOCIETY (DETROIT) PLAN,
J. A. M. A. 103:759 (Sept. 8) 1934.

Complete medical service without the use of the insurance principle is being offered and given to wage earners of Detroit through a plan developed and put into operation by the Wayne

County Medical Society, Detroit. A demonstration set-up is bringing medical care to hundreds of employed persons of small means, people who do not want paternalism or charity but merely credit.

The Wayne County Medical Society plan, originated by Dr. Ralph H. Pino of Detroit, was very carefully scrutinized by the Wayne County Medical Society for more than eighteen months before it was approved by the society's council, Feb. 16, 1934. The board of trustees then appropriated sufficient money to inaugurate and maintain a bureau to put the plan into operation. It is owned and operated exclusively by the Wayne County Medical Society, and the administrative office is located in the society's building at 4421 Woodward Avenue, Detroit.

SOURCES OF REFERRED PATIENTS



Eliminating the salaried class, which is able to handle its own medical problems, the remaining three classes of people in Detroit can procure medical service through the agency of the Wayne County Medical Society:

1. The unemployed on welfare rolls receive home and office medical service by the family physician, dentist, and so on, through the Medical-Dental Bureau, operated by the Wayne County Medical Society in its building. The cost of this agency is met by the FERA.

2. The unemployed not on welfare rolls are cared for in Detroit through the Medical Relief Committee on the Wayne County Medical Society. The family physician or volunteers who serve these people with home and office care at no fees, or at small fees assist the patient to maintain his self respect.

3. Employed persons earning small wages or salaries are cared for in Detroit by the bureau developed from the Wayne County Medical Society plan.

This plan offers complete medical care, comprising the services of physicians, hospitals, dentists, nurses and pharmacists, at a fee that can be paid by easy time payments within a year's time or less.

The purpose of the Wayne County Medical Society Bureau is to assure employed people of modest income that they can go to the physician of their choice and receive necessary medical service when they need it. Furthermore, the bureau works out a plan for them whereby the account can be paid from week to week.

Those people who for financial reasons are neglecting their health are encouraged to get in touch with the bureau. Because they have no cash reserve is no reason that medical service must come to them through the agency of free dispensaries and tax supported hospitals and clinics.

The bureau is a demonstration in cooperation. Five professional groups (physicians, hospitals, dentists, nurses and pharmacists) are working together to provide high-grade services to the employed worker of small means. Industrial concerns, realizing that healthy workers are more efficient and desirable, cooperate by (1) telling employees to see their family doctors; (2) verifying employment wages and giving credit information to the Bureau on request; (3) assisting in the collection of a fair fee, based on the employee's ability to pay.

Some idea of the immense amount of work necessary to make this plan a success may be gained from the following data: There are over 7,000 units of medical service (physicians, dentists, nurses, pharmacists and hospitals) in Detroit and Wayne County. There are over 2,400 industrial units or employers (factories, shops, and the like) in the same area. The cooperation of all these is necessary to the complete success of this demonstration. The staff at the Wayne County Medical Society is working constantly to establish these contacts and to create the organization necessary to care for all patients who apply at the bureau for aid. It will require more than a year of intensive effort to complete arrangements so that every employer and worker in Detroit and Wayne County will know of this opportunity for service offered by the Wayne County Medical Society.

The essential features of the medical service plan may be briefly summarized as follows:

1. The Wayne County Medical Society headquarters become a coordinating center (with a social service set-up) for those cases which require assistance in obtaining and paying for

complete medical service, including hospitalization and medical, dental, nursing and pharmaceutical service.

2. The members of the professions become the active staff caring for patients. All forms of medical care, consultation, x-ray and laboratory procedures are to be performed in the office or laboratory of the physician or at the hospital where he takes his patients.

3. This plan includes hospitalization—all the major hospitals of Detroit are cooperating, except one.

4. Arrangements have been and are being made with industrial concerns to make this service known to their employees. The factories and shops are cooperating in giving information and in the collection of accounts. To date the plan has received an enthusiastic welcome by each employer approached.

5. All cases in which the benefits of the coordinating plan are desired will be registered at the Wayne County Medical Society headquarters and referred to the family doctor, if the patient has one. If the patient has no physician, he is asked to select one. The patient will be given an identification card to be presented by him to the physician selected.

6. If several physicians and a hospital cooperate in the care of a case, the bills for fees will be combined into one bill and terms will be arranged according to the patient's ability to pay. The physician and the hospital set the fees—not the bureau. Payments received by the central bureau will be distributed to each cooperating physician, hospital, dentist or nurse.

7. This plan preserves the recognized patient-physician relationship. It does not affect compensation cases. The patient always has a free choice of physician or dentist and the physician has free choice of hospitals, specialists and laboratories, exactly as carried on in private practice.

8. The most important feature of this plan is that it places complete medical and hospital services within the reach of every worthy patient and provides an easy payment plan for the settlement of medical bills.

9. The plan should increase the health and happiness of Detroit and Wayne County citizens, as it provides a method whereby people can procure needed medical services. It should remove a large proportion of the financial reasons for delaying medical service. The consolidation of medical and hospital bills, with the arrangement of definite terms at the time the service is rendered, should result, with the cooperation of the employer and all concerned, in an increased ratio of collections.

10. Physicians send their bills computed at their usual fees for these patients to bureau headquarters, giving certain details of their charges. The physician does not make collection of these charges—the central bureau makes arrangements for collections and has the cooperation of the employer. To defray the cost of operating the bureau, 10 per cent of sums actually collected is retained by the bureau.

The bureau is under the direct financial and executive control of the board of trustees of the Wayne County Medical Society. An advisory committee, called the Board of Arbitration, aids the board of trustees with recommendations regarding details of operation, handles disputes, and assists the smooth performance of the bureau. Representatives of the various cooperating professional groups are seated on the Board of Arbitration. The bureau is under the coordinating supervision of the executive secretary of the Wayne County Medical Society.

The Wayne County Medical Society Bureau has grown so rapidly that statistics are obsolete almost before they can be published. The plan has received a hearty welcome from every industrialist to whom it has been explained. The total number of employees of the industries now cooperating with the bureau is approximately 229,980. Industrial concerns have various methods of cooperating with the central bureau (such as by pay-roll deductions and employee loans), but they all agree on one point: they are willing to extend every courtesy to the medical organizations if they can cooperate with one center, but it is impossible for them to deal with over 7,000 individual units who serve the public. Their reason is obvious. One central bureau in the medical society would entail only one deduction from pay-rolls per month to cover the medical welfare of their employees; the bookkeeping is thus greatly simplified. If, however, the industrial concern attempted similar cooperation with thousands of individual physicians, dentists and hospitals, it would require a tremendous amount of detailed and expensive bookkeeping. Centralized bookkeeping and collections are vital in obtaining the cooperation of large employers of labor. They hesitate to promise cooperation except with one center.

During recent months, welfare agencies in Detroit (like other large centers) have been flooded with requests for free medical care. When approached by the Wayne County Medical Society and asked to cooperate with its bureau, the officials in charge were glad to conserve public funds by referring all patients able to pay something for medical service to the bureau. These patients are always returned to their family practitioner with a plan of deferred payments. The majority of these patients sought charity because they did not have sufficient cash in reserve to meet the full fees incident to a medical emergency. Their prime need was credit—not free medical care. Already many families have been spared the humiliation of charity by the alert cooperation of the investigators in Detroit's public charity institutions. The bureau will continue its contact with free and part pay dispensaries and clinics with a view to returning as many cases as possible to the private practitioner of medicine in order to strengthen the traditional physician-patient relationship.

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Since Feb. 16, 1934, the bureau has been of service to 937 patients (as of Aug. 18, 1934) and has not refused service to any deserving applicant. In every case service was rendered immediately without red tape. The universal gratitude of patients has been encouraging.

Patients who erroneously thought they could not pay for medical service have contributed to the bureau in small weekly instalments of one, two and three dollars (occasionally a little more) the surprising total of \$13,140.13 (as of Aug. 18, 1934). The rapid acceleration of total payments as the number of cases increases is illustrated by the fact that while \$3,563.82 was collected during the month of July, a total of \$3,417.81 was paid in during the first sixteen working days of August.

The bureau has not advertised its services, because a large volume of cases could not be handled by the present small administrative staff of the bureau. Experimental publicity has been released to the employees of one large manufacturing concern by a write-up in the employees' monthly magazine. The following quotation from this publication illustrates the manner in which the bureau intends to route sick employees or members of their families to their private practitioner, and if financial problems cannot be solved by him, to work out a plan for the benefit of the patient and the doctor:

In case of illness in your family, call your family doctor. Let him examine the patient and make his diagnosis. If you are unable to pay cash for the necessary treatment, ask your doctor to refer you for help to the Wayne County Medical Society Service Bureau, Wayne County Medical Society Building, Detroit. The Bureau will work out an easy payment plan so you can get rid of that pain or sickness today. There are no dues, service charges or interest for you to pay.

The bureau believes that this type of publicity will increase the number of patients seeking medical care in physicians' offices and will lessen the dispensary load and taxpayers' burden.

During the last few years the medical profession has been subjected to unjust and severe criticism, and many opportunists have taken advantage of the smoke screen to formulate schemes (usually socialistic) having "bigger and better" medical service to the middle class patient as excuse for their meddling. Through its bureau, the Wayne County Medical Society of Detroit is seeking to demonstrate that medical care can be supplied those who need it—not through insurance, not through government or political agencies, but through the sane and unselfish work of the individual doctor of medicine coordinated by his county medical society.

WYNNE, S. W.: PUBLIC HEALTH VS. PRIVATE PRACTICE,
Survey Graphic 16:394 (Jan.) 1930.

The time is not far off when every large city will have district health centers in strategic points, just as today it has district police and fire headquarters. The people of a com-

munity would soon protest vehemently if their particular district were not supplied with adequate police and fire protection. There is just as much need in a district for health protection, and it is to the district health center of the future that one looks for that protection. The health center will serve those who are too poor to pay the private doctor—and it will also provide the physicians of the neighborhood with a central service in which roentgen facilities and every means of biologic analysis will be at their disposal. The physician is the most important factor in the whole public health movement, and the development of these neighborhood health centers should, and would, in no wise interfere with the relationship of the patient to his private physician.

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