II. SOCIALIZED MEDICINE

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INTRODUCTION

Some sixty years ago, when Grandmother or one of the children became ill, Granddad hitched up Rubber and Dexter to the spring buggy, drove six miles into town and brought old Doctor Whitcomb back with him. When the visit was over Granddad drove him back. There was nothing much said of pay, probably, until the prune harvest, when the farmers paid their bills for the year. The old doctor never sent out statements, so many of his services were never paid for. Some, who could not pay in actual money, paid in chickens, eggs, a turkey, or a pig, now and then, but whether they could pay or not the doctor took care of them just the same. The medical knowledge available in that day was limited, but what there was was available alike to all classes of people.

Times have changed since then, and that is not true of medical service today. No longer is it possible for the doctor to carry in his head the sum of his knowledge, and in his little grip most of his necessary equipment of instruments and drugs.

In the past fifty years there has been wonderful developments in the fields of both medicine and science. From a comparatively simple art, medicine has been transformed into one of great complexity, the whole structure of which is complicated and expensive. Young men desiring to practice medicine must undergo a period of long and

intensive training. The medical centers of today are the highly organized hospitals where clinical instruction is carried on by specially trained doctors, nurses and technicians. Because of the new discoveries there is necessity for costly apparatus and supplies unheard of a generation ago. For the satisfactory diagnosis and treatment of the sick today, the physician or the specialist needs much more than the clinical thermometer and the stethescope. He needs such scientific equipment as the sphygmomanometer, sphygmograph, cystoscope, bronchoscope, respiration calorimeter, cardiograph, X-ray machine, apparatus for determining basal metabolism, and numerous surgical instruments, as well as various physiotherapy machines. He needs laboratory facilities for the examination of urine, blood, stools, sputum and various specimens which aid in the diagnosis of disease.[1] For many of these instruments and procedures specially trained persons are necessary. Lastly, every medical practitioner needs access to a complete scientific library. He must become acquainted with the vast technical literature of science; he must acquire proficiency and skill in a difficult and ever-changing art, he must utilize wisely all the resources of hospitals and clinics.

Obviously all these aids increase the efficiency

[1] Moore, Harry H. American Medicine and the People's Health D. Appleton and Co. 1927 Page 22

and ability of the general practitioner and the specialist, but they are costly. It follows then, that the increase in the cost of medical care has been inevitable, and because there will be further improvements and developments the probability is that the costs will not be decreased.

Another factor in the high cost of medical care is that since the very early beginnings of medicine up until the present day, this form of service is, and of necessity must be, a personal one. In a day when mass production and standardized commodities are universal, medical care, by the very nature of its service, has remained unchanged. The individual needs of the patient have always required and still require the individual skill and attention of the practioner for diagnosis and treatment. While household commodities, garments and machines can be produced in quantities, with standardized methods, the patient, irrespective of his economic level, must be given individualized, personal service by the physician, the dentist, and the nurse. With the increase in knowledge, equipment and techniques, and in light of the fact that medical service must be a personal service, the tendency, obviously, has been to increase, rather than decrease, the individuals engaged in rendering such care. Personal service is a costly service; it cannot be standardized according to

mass production methods. The majority of the people needing medical care are in the low income groups, therefore the greatest burden is placed on those who are least able to bear it.

It is readily apparent that there is need for a change--for some form of adjustment in the methods of paying for medical care for those in the low income groups, therefore it is important that present forces be directed toward socially desirable adjustments. The chief consideration should be the welfare of the individual and the group, with due regard to the remuneration of those who give medical and health service. Whatever form these adjustments may take, the problem of dealing effectively with disease, thus making available to all the people a higher degree of health and happiness should be the goal to strive for.

THE PROBLEM

One of the biggest problems confronting the American people today is that of providing medical care to all at a price which they can afford to pay. Franklin D. Roosevelt, in 1932, when he was Governor of New York State, wrote: "Because large groups of the population seem unable to provide themselves with adequate medical services, the problem was of major importance five years ago. It is of vastly more importance now, because of the change in the economic situation." If this was true in 1932, how much more true it is today in 1939, when the economic situation has grown worse, when there has occurred another depression, or a retrogression perhaps of the depression of 1929 and 1930.

We have come to a crisis in medical care. This is revealed in the comprehensive five year studies made by the committee on the costs of medical care.[2] These studies show that while the average pay of physicians and others engaged in health work is not high, and while in many individual cases the actual pay is insufficient, adequate

[2] Falk, I.S., Rorem, C.R., Ring, M. D. The Costs of Medical Care The University of Chicago Press 1933

medical attention is beyond the reach of millions of people. While medical knowledge has been progressing rapidly for the last fifty years, the application of that knowledge to the needs of the general public has lagged. Therefore, we must seek a solution to this problem. We cannot go back to the old ways; we must go on to the new.

So far measures proposed to meet this crisis have disclosed a clash of philosophies, as was evidenced forcefully in the majority and minority groups of the committee on the costs of medical care.[3] The majority group believe that the provision of adequate medical care is a social problem and responsibility, and recommend sweeping changes and reorganization in the present system. The minority group believe that inasmuch as the relationship between physician and patient is always a personal one, it can never be socialized. In sympathy with the philosophy of the majority group, there is a large number of scientifically trained persons who are more interested in preventing and curing disease in the most socially effective manner, thus bringing health and prolonged life to all the people, than in maintaining the old "personal" relationships

[3] Ibid., Vol. 27

between physician and patient. On the other hand there are many doctors who hold to certain professional ideals and traditions handed down from the earlier days of American individualism and free competition, who believe that the quality of medical care will be lowered if these factors are eliminated.

DEFINITION OF TERMS

In general there has been a great deal of confusion concerning the terms and definitions used in connection with the subject of medical care. Public medicine, state medicine, group medicine, and socialized medicine are terms coined in the last half century, and frequently used by both lay and professional people to designate this social change in medical care. Economists and sociologists, however, point out the differences in definitions of the terms, and how they are often misused.

To understand how the terms have been interpreted, let us go back a few years. In 1900, Samuel W. Abbott, then Secretary of the State Board of Health of Massachussetts, wrote a paper on "The Past and Present Condition of Public Hygiene and State Medicine in the United States." In this paper he accepted the definition of hygiene, proposed in 1879 by John S. Billings:

> "In its broader sense, the study of hygiene includes the examination of the conditions which affect the generation, development, growth and decay of individuals, of nations, and of races, being on its scientific side co-extensive with biology in its broadest sense, including sociology, rather than with physiology merely, as some writers state."

Dr. Abbott then suggested the following definition of state medicine, "The term state medicine is a broader term than public hygiene, since the former includes the latter, together with legal medicine, medical education,

and all subjects which treat of the relation of the physician to the state."[1]

In 1922, at the meeting of the American Medical Association, that group defined state medicine as ".... any form of medical treatment, provided, conducted, controlled, or subsidized by the federal or any state government, or municipality, excepting such service as is provided by the Army, Navy, or Public Health Service, and that which is necessary for the control of communicable diseases, the treatment of mental disease, the treatment of the indigent sick, and such other services as may be approved by and administered under the direction of or by a local county medical society, and are not disapproved by the state medical society of which it is a component part."[2]

According to Harry K. Moore, the above definition is no definition at all, but rather a generalization including those measures which at the time of the resolution appeared to be disapproved by the majority of the House of Delegates, and which were condemned under a

[1] Samuel W. Abbott, "The Past and Present Condition of Public Hygiene and State Medicine in the United States," Monographs on American Social Economics (Herbert Adams, Editor), No. XIX, 1900, P. 6

[2] J.A.M.A., Vol. 78 (June 3, 1922) p. 1715

convenient term of approval, namely "state medicine."[3]

Dr. Hugh Cabot, Dean of the Medical School of the University of Michigan seemed to understand how confused the American public had become regarding this term. He says:

> "The phrase state medicine is commonly used to convey some ill defined arrangement by which the state shall become the responsible source of medical practice. It is probably often intended to convey the idea that all physicians should become salaried officers of the state. In this form it is probably rarely used as a constructive suggestion but is intended like the Democratic party in the days following the Civil War to serve as a threat rather than a plan. . . . If, on the other hand, we understand this somewhat loose phrase to mean progressive assumption on the part of the state of responsibility of health questions, such a situation now exists."(4)

In 1924, the Massachusetts Department of Public Health defined state medicine as "medical service to the individual at the expense of the community."

Harry H. Moore differentiates between state and socialized medicine in that the former, state medicine, is merely controlled by the state, while socialized medicine is that which is controlled by any social group. He goes on to say that public health work is included in

3 Harry K. Moore, American Medicine and the People's Health D. Appleton and Company 1927, p. 452

4 Hugh Cabot, "Compulsory Health Insurance, State Medicine or What?" Boston Medical and Surgical Journal, Vol. 182 (June 10, 1920), p. 597.

state medicine. From the standpoint of sociology and political science, he says that "socialized medicine, as contrasted with the private practice of medicine, is the science and art of preventing and curing disease through collective effort with the financial support of one or more social groups or governmental units," and that state medicine "is merely that form of socialized medicine which is supported and directed by local, state or Federal government."[5]

In contrast to this, Dr. Joseph Slavit says that mere group action is not socialization. A private stock company or a railroad are examples of group action, but are not forms of socialization. To be truly socialized, Dr. Slavit states, the enterprise or activity must become public property, as is true of the post office or schools; must be supported by public funds, either through taxation or fixed and reasonable charges; its services must be available to all without discrimination; and its workers would be paid for their services by the state, as are the letter carriers, or the school teachers. To make socialization complete from all standpoints there must be added civil-service tenure and self-government of the workers concerned, with a proper re-

[5] Harry H. Moore, American Medicine and the People's Health D. Appleton and Company 1927, p. 453

gard for the interests of both the service and the personnel engaged in it. This, Dr. Slavit says, is "not a doctrinaire definition of socialization; it is a profound sociological concept."[6]

[6] Joseph Slavit, M.D. "Medical Service at Public Expense: An American Plan for Medical Care" Debate Handbook, Socialized Medicine (Bower Aly, Editor) 1935-1936 p. 59

The Present Status of Medical Service

Most modern industries and enterprises of the present day have some definite form of organization, with a high degree of specialization. The educational system in any given city, county, or state is under an administrator, who has many assistants, showing a well-defined type of organization. Even in small communities where there is only one school, there is organization. The principal is the administrator, answerable to the school board, and under him are the various assistants or teachers.

Medical service cannot be defined in similar terms of organization. There seems to be lack of organization, but there is highly developed specialization. Even in early and medieval times there was specialization, in that barbers performed such surgery as was done, and medicine was practiced by the priest or the magician.[1] Since the Renaissance, however, surgery has been raised to the high status of other forms of medicine, and with the ever increasing store of knowledge there has come into existence every kind of specialist, in addition to the well-trained general practitioner.

[1] Siegerist, Henry E. "The Physician's Profession Through the Ages." Bulletin of the New York Academy of Medicine. December 1933

Except for those working in clinics, these physicians work as individuals. The individual doctor renders service to the individual patient. The general practitioner refers the patient, when necessary, to the specialist, and he in turn, individually, treats the patient. The patient may be referred to several specialists before the real diagnosis is made and treatment is instituted. Therefore, instead of receiving one bill in the end for medical services he receives as many bills as men he has seen. If specialists fail to report back to the general practitioner, as happens in many instances, this man hears no more of his patient.

The high degree of specialization, as it now exists in the modern sense of the term, is becoming an increasingly important economic factor to the consumer. Probably the greater percent of human ailments could be treated successfully by the general practitioner, but the trend is toward the specialist. One evil result of this is that many times the patient, instead of the family doctor, chooses the specialist; the specialist, because he is a little one sided in favor of his subject, or for various other reasons, treats the patient for some ailment which may not be the primary seat of trouble.

In addition to the general practitioner and the

specialists there has developed other agencies engaged in health work,--the druggist, the free clinic, the pay clinic, the hospital, the diagnostic laboratory, the trained nurse. But while they are all highly trained and specialized, and are engaged in the same kind of work as the physician, they are in no way connected with him, in terms of organization. They have grown up without relation to any comprehensive plan. Although they are not organic parts of a system, as a single school is part of an educational system, these institutions are accepted as necessary in the modern practice of medicine.

In discussing the present organization of medicine any paper would not be complete without mentioning the present status of public health. This branch of service represents the most efficiently organized branch of medicine today.

Before the establishment of boards of health, health and sanitation problems were handled by state or local medical associations. The various district and county medical associations sent reports of epidemics and sanitary conditions to the state medical associations. As knowledge regarding the spread and control of disease increased and as it seemed necessary to have some authority in the control, permanent boards of health were established by the state. State legislatures appropriated

funds for the establishment and maintainance of these boards and departments of health. Gradually laws and regulations have been passed pertaining to health matters as the needs became apparent.

The first board of health was established in the state of Louisiana in 1855; this was followed by Massachusetts in 1869, California in 1870, Minnesota and Virginia in 1872. At first the duties of health departments were very limited, consisting chiefly in the control of water supplies and the suppression of epidemics; later departments of vital statistics for the registration of births and deaths were added. Thus from small beginnings these departments have gradually developed until at present their activities and powers are extensive.

The functions of the state departments of health consist largely in the control of communicable diseases, the collection of vital statistics, the control of water supply, the disposal of sewage, food inspection, the maintainance of diagnostic laboratories, and the dissemination of information regarding disease. Laboratory service is rendered free of charge to both physician and patient, the motive being to control communicable diseases. Some state laboratories manufacture and distribute biological products. In recent years much work has been done towards the prevention of certain diseases,

and attempts toward the control of the spread of such diseases as tuberculosis, hookworm disease, syphilis and gonorrhea, have led to the establishment of clinics for the treatment of these diseases. Thus the functions of the health departments, which began as preventative, have come to include curative as well.

The functions of local health departments, which include city and county, are very similar to state departments, with perhaps the difference that they deal more directly with the people. In the larger cities the health department staffs may be very large, employing from twenty to one hundred persons. In some cities and counties the local governments maintain hospitals and clinics.

In addition to the state and local health departments the Federal Government at Washington has established the United States Public Health Service, whose chief function is to conduct research, and to advise with and assist state and local departments. The present Public Health Service developed from the Marine Hospital Service, which was created to furnish medical care to sick and disabled seamen of the merchant marine, and to aid in the control of diseases imported into the United States. The functions of the United States Public Health Service today are:

1. The protection of the United States from diseases from without.

2. Prevention of interstate spread of diseases and the suppression of epidemics.

3. Cooperation with state and local boards of health.

4. Investigation of the diseases of man.

5. Supervision and control of biological products.

6. Dissemination of health information and public health education.

7. Care and treatment of disabled seamen belonging to the merchant marine, as well as of certain employees of the Federal Government. (2)

In studying the activities of the public health services in the United States there are two degrees or organization noted. First: in some activities there is a great amount of authority exercised, as in the collection of vital statistics and other activities. Second: in dealing with other needs, the local or state department may organize activities through the exercise of leadership without any authority. The one kind of administrative activity, accompanied by authority and control may be referred to as "organization", while the other, leadership without authority, is described by the term, "coordination".

We see, therefore, that public health work has achieved much with both organization and coordination,

2 "United States Public Health Service--Its Evolution and Organization," P.H.R., Vol. 36 (May 27, 1921)

but there has been no attempt to deal systematically with all the health and medical problems of local community and state. The general practioner and specialist, on the one hand, have dealt almost entirely with curative treatment of disease. Private health agencies here and there have furnished facilities for the treatment and prevention of specific diseases, such as tuberculosis. Public Health has undertaken the control of communicable diseases. The state provides medical education and regulates the practice of medicine.

It is apparent, from this brief resume, that there is rather a confused state of affairs in the medical world, and that there is need for some kind of integration of all health and medical services. In general, one must ask: is adequate health and medical service of all kinds available to all the people at costs within their means? No agency, institution or person now exists in the state, municipality or county, responsible for the consideration of this question, or for the organization and coordination of all health and medical activities to provide for all the people a complete program of services.

HISTORY OF MEDICINE

To discuss the historical background of socialized medicine itself is difficult, in that this movement is so closely interwoven with the whole field of medicine, and begins fundamentally with the very earliest beginnings of medicine. Whenever and wherever there was any feeling and manifestation of responsibility on the part of the state toward the health and physical welfare of its people, there were trends toward the socialization of medicine, according to the common understanding of the term.

In very early times primitive medicine was closely associated with magical and religious beliefs. Slight ailments, it was felt, needed no explanation, and were treated by the patient or relatives with simple remedies, but serious ailments were another matter, and had to be explained. These explanations took the form of magical or religious rites. In some cases it was thought that harm had been done to the patient by some other man or a demon, by introducing an object into the body of the patient by means of magic; in other cases it was believed that the diety sent disease as a punishment for sin, or that a demon had taken possession of the patient's body. The treatment, therefore, was either magical or religious,

depending on the belief as to the cause of the ailment, and it was necessary for the physician of that period to be priest, magician and physician all at the same time in order to treat his patients.

Because the physician's profession gave him power over the people, and because a misuse of that power would be a serious menace to society, rigid rules were established regulating the physicians'behavior. The first rules of this kind were found in the Code of Hammarubi in 2000 B.C., when the surgeon was declared liable for his actions, and in case of a fatality in an operation his right hand was cut off. Similar regulations were prevalent in ancient Persia, and in addition it was the rule that the surgeon could not practice until he could show that he had done three successful operations, not on Pharisees but on infidels. Here can be seen the early supervision by the state of medical practice, with a concern for the welfare of the patient.

The art of healing during these early years was influenced greatly by the Greek belief in the god, Asclepios, who, according to legend, was cut out of his mother's womb by Appollo, when slain by his arrows. Asclepios was taken by Appollo to the cave of Cheiron, the centaur, and there taught the medicinal virtues of herbs, together with many incantations. According to belief, Asclepios became a physician who cured many sick men, but because he had the presumption to resuscitate some from the dead, was

struck by Zeus with his thunderbolt. The followers of Asclepios called themselves Asclepiads, and their medical practice consisted of miracle cures on a purely religious basis.

Later the healing art was further developed in the schools of the pre-Socratic philosophers, and reached its highest development in the time of Hippocrates. These physicians were organized in a kind of guild, the patron of which was Asclepios, hence they called themselves Asclepiods, also. They were craftsmen and received their training by apprenticing themselves to older doctors.

There were few doctors in Ancient Greece, and they travelled about, practicing their art from place to place, wherever they might chance to be. However, the larger cities had their own doctor, who was in the service of the city and whose salary was raised by a special tax. Special physicians were employed in times of wars and epidemics. Thus is noted the first real incidence of the state feeling responsible for the health of its people. The Greeks attitude toward the human body was one of high esteem. Health was most important, in their minds, and the ideal man was the person who was noble, beautiful and perfect in both body andsoul. They eomsidered disease a curse because it changed man from the condition of perfection and made him inferior.

The Roman physicians, who were slaves, were very much inferior to the Greeks in medical knowledge, and

strongly opposed them when the Greek physicians immigrated to Rome. As wars broke out, however, and physicians were greatly needed, they soon recognized the superior ability of the Greek doctors and encouraged them to come to Rome. Julius Caesar, in 46 B.C., accorded the Greek physicians great privileges such as exemption from taxation and military service, and granted all free born Greek physicians on Roman soil the right of Roman citizenship.[1]

These privileges induced many unprincipled men to call themselves doctors, as there were no standards or requirements placed upon the profession by the state. Therefore it became necessary to establish certain restrictions, and this was done in the time of Antonius Pius. According to the size of the city five, seven or ten doctors were allowed to practice, and in order to do so they had to prove that they possessed medical knowledge. This form of license, as it were, protected the people from charletans and imposters, and guarded the rights of competent physicians.

During Roman times, many families had their own family physician. He was paid an annual salary for which he treated the whole family for the year. A physician at court received a salary approximately equal to $12,000

[1] Siegerist, Henry E. "The Physician's Profession Through the Ages." Bulletin of the New York Academy of Medicine. December 1933

in our money, and some physicians in the capital had an annual income of about $35,000.

With the coming of the Christian religion, and its emphasis on healing, the physician found his services uncalled for. This new teaching promised healing for both spiritual and physical ills, and drew many followers among the sick, the weak and the crippled. The duty of the Chrisitan was to care for the sick and injured, for which he would receive special grace. Hospitals were started, and later convents and monasteries began caring for the sick, all this to the exclusion of any medical services of the physicians. These attitudes prevailed for several hundred years, and then there was a change of thought, for they found that sick people could be taken care of much more efficiently by giving them medical treatment as well as nursing care. Thus the church and medicine became reconciled and the Christian monks and priests began studying medicine.

A medical school was established in Salerno during the 10th century, the doctors of which were laymen as well as clerics. This school did much to improve the medical knowledge of the time. In 1224, the Emperor FredericII passed laws regulating the medical conditions of his empire. Those desiring to practice medicine had to pass certain strict requirements. These included three years study of philosophy, five years of medicine, one of

practice, and then the candidate was required to pass an examination before a license was given him. This is the first time in European history that medical practice was regulated by public law.

Following the extablishment of the medical school at Salerno, universities sprang up all over Europe, and while medical education was purely theoretical at this time, the foundation was laid for greater medical advances. From this time on the physician was looked upon and did become a scholar and a doctor.

The medical profession then passed through a period commonly known as the Dark Ages, when there were no apparent advances made, as did all the other arts. During this period, the physicians attempted to become body-physician to persons of noble rank, thus assuring themselves of a definite income. In this way they could devote a great deal of their time to charity work. In the more democratic countries, a physician was attached to a group of families, which is probably the beginning of our tradition of the family physician.

In the early period of medicine the physician and healer came from the upper and middle classes, but with the sweep of democracy at end of the 18th and during the 19th centuries class distinction was abolished, and anyone who had the will could enter the profession. This probably was a great advance for medicine as well as the

other arts. Although health and disease were considered an individual matter and responsibility, humanitarian ideals prevailed to such an extent that a great deal of charity work was done and more hospitals were erected than ever before. The doctor became a member of a highly respected profession and was awarded great social privileges because of his academic education. The 19th century was an age of awakening sciences, and because the doctor was a representative of the natural sciences he was so much the more esteemed.

Great names stand out during this period of medical history, and great discoveries made possible further advances in science in the years following. Louis Pasteur, the French Chemist, firmly established the germ theory of disease; Robert Koch, a German physician, isolated and grew in pure culture the tubercle bacillus; Metchnikoff, a Russian, demonstrated the phagocytic action of the leukocytes; Klebs, a Prussian, and Eberth, a German, described at about the same time the typhoid bacillus; Lister, an English physician,applied Pasteur's discovery to surgery, out of which has come modern asepsis.[2] These are only a few of the great men who contributed to medical science; there were many more.

[2] Mustard, Harry S., M.D., An Introduction to Public Health The MacMillan Company, New York 1935

During the last half of the 19th century another branch of medical science came to the fore. This was public health and hygiene, and its stimulus was the outbreak of such serious epidemics as smallpox, diphtheria, cholera, plague, and other diseases. Men began to think of ways to curb these diseases after they had appeared, and further, to prevent subsequent outbreaks. It was noticed that such diseases as cholera and syphilis spread along lines of travel, and this made thinking people feel the need for strong organizations to control and combat such diseases. Establishment of Boards of Health resulted.

The first countries in Europe to establish such boards were Sweden and Denmark; England followed in 1848, and the first in the United States was the Massachusetts State Department of Health organized in 1869.[3] By 1900 about half the states had health departments, and at the present time all the states have organized Boards of Health. Some function more effectively and achieve better results than others, especially if they are free from political control and influence. Viewed as a whole, these departments have made wonderful progress in their comparatively short existance.

With regard to the Federal Government, there has never been a national department of health, with a secretary in

[3] Weinzirl, John, M.S., Ph.D., General Hygiene and Preventive Medicine Lea & Febiger, Philadelphia 1937

the President's cabinet. In 1879 Congress authorized the formation of a national"board" of health, but there was no definition of its functions and duties. Congress failed to appropriate any money for its operation, and in 1893 the act creating the board was repealed. The United States Public Health Service, established in 1798 is the principal health agency of the Federal Government. Its administrative officer is a Surgeon General, and it is a bureau in the Treasury Department. As this department was created purposely to prevent diseases from being carried into this country by foreigners from abroad, that has been its chief function, but gradually it has assumed other duties which are quoted here as follows:

> "To prevent the importation of disease from abroad; to prevent the interstate spread of disease in this country; to investigate the cause and prevention of diseases of public health significance; to supervise the purity and potency of biological products in interstate commerce; to assist state and local health departments with their public health problems; to render medical service to certain beneficiaries." (4)

The Public Health officer, in most instances, works with the state and local health officers in any serious interstate health situations. Very rarely does he assume control or supersede the authority of the local health officer.

4 Mustard, Harry S., M.D., An Introduction to Public Health The MacMillan Company, New York 1935

The next step was the establishment of bacteriological laboratories to facilitate the work of the Boards of Health. A dramatic chapter in the history of public health was the opening of the New York bacteriological laboratory. Dr. Hermann Biggs, a far-sighted man, was then Commissioner of Health. On August 10, 1892, cholera broke out on the Hamburg line. On the 13th, the Moravia arrived in New York harbor with cholera on board. Subsequently five more ships arrived, all with cholera aboard. This was Dr. Biggs' golden opportunity, and the result was the establishment of the New York bacteriological laboratory. For the first time cholera was met successfully.

As medical science has changed down through the ages, so has the attitudes of the people changed. Those public spirited citizens who have a feeling of civic pride also have a feeling of civic responsibility. They no longer accept wholeheartedly the concept that health and welfare is an individual problem; it is a community problem, for what affects one member of a community may affect many members. It has been seen that governments are assuming some responsibility, which seems to be increasing more and more. Foreign countries have for many years had forms of health or social insurance, as a means of making possible medical care to the lower economic classes. The

United States at the present time is going through a period of disorganization. There is a definite maladjustment between the medical knowledge available and the development of machinery for its utilization. This condition may be likened to a social phenomenon which William F. Ogburn describes as "cultural lag."[5] Just what form the solution will take is hard to predict at the present time. Experiments are being made in many parts of the country, and it is safe to say something practical and workable will evolve from the present disorganization.

[5] Ogburn, William F., Social Change (Huegsch, 1922)

THE NEED FOR MEDICAL CARE

In studying the incidence of illness and the need for medical care, the only statistical records available for many years have been the mortality rates in those states included in the Registration Area for deaths, and these were not at all reliable in providing an insight into the frequency of illness, especially of the non-fatal types.

There has been an appreciable decline in the mortality rates, as noted in the 1900 and 1930 death rates. In the age group above 55 years, the decrease was slight; in the middle age group, the decrease was greater; in the age group from 10 to 35 years, the decline was 50 per cent, from 5 to 10 years, 60 per cent, and below 5 years the reduction was 66 percent. During this thirty year period, these surprising changes in the death rates have taken place because of the application of the new medical knowledge to certain diseases which before were markedly serious in results--namely, typhoid fever, small pox, diphtheria, diarrhea and enteritis, and a few others.

But what of the incidence of non-fatal illness? and in what groups is there greatest prevalence? and is the modern medical knowledge and facilities available to those who need it most? Notwithstanding the fact that medical

knowledge has increased greatly, that physicians in private practice are utilizing to a considerable extent these discoveries, and that health departments are conducting effective programs in the field of prevention, sickness and disease still persist.

Every public health nurse, in the course of her work, has found an overwhelming per cent of the school children with decayed teeth, with large, diseased tonsils, with nasal obstructions causing mouth breathers. These are only the minor defects. There are many others which the nurse sees in the homes--scarlet fever with serious complications, pneumonia, digestive disturbances, measles, whooping cough, tuberculosis, and not the least important, the orthopedic defects. These people in the rural areas are usually so poor they never think of calling a doctor unless it is a matter of life and death, for they never know how the bill is going to be paid.

The rural nurse also finds many mothers ill, overworked, needing medical care--perhaps an operation--but with no prospects whatever of receiving this care. These mothers all tell pretty much the same story--no prenatal care and supervision, delivery at home with the doctor being called in at the last moment, a few days in bed with the husband and older children carrying on the work, or perhaps a neighbor coming in a few hours each day, until the mother can drag her tired, weak body from bed

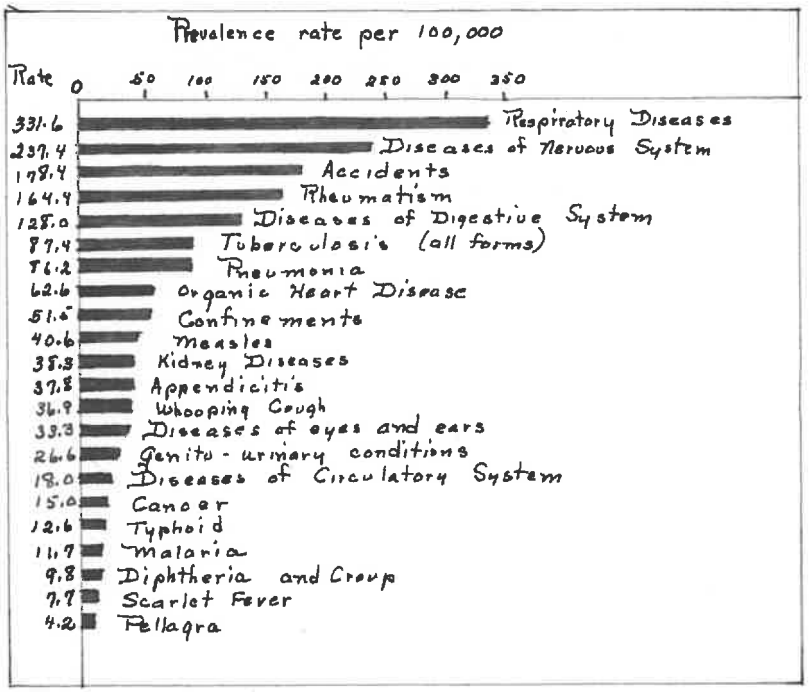
and begin the endless round of household duties again. No wonder so many of our mothers are old, broken down women at forty and fifty years of age!

In attempting to prove any point in these modern times mere observation alone will not suffice. It is necessary to have some sort of statistics.

Statistics of illness may be gathered according to two ideas: first, the prevalence of illness, which is measured by the number of persons sick on a particular day; secondly, the incidence of illness, determined by the number of illnesses occurring in a specified period of time. This has been done by two large groups, the Metropolitan Life Insurance Company, and the Committee on the Costs of Medical Care.

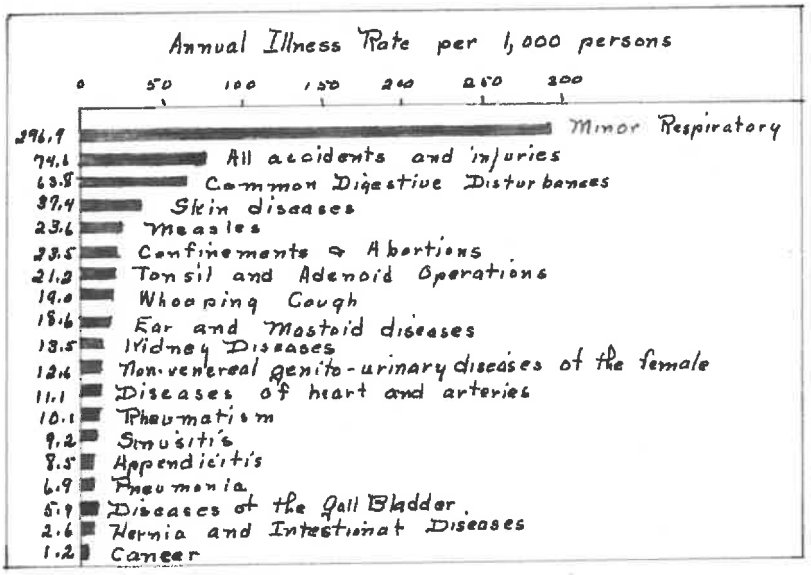
Some fifteen years ago the Metropolitan Life Insurance Company conducted a survey of the prevalence of illness, and the following chart shows the results of this survey in terms of the number of persons ill from each of the principal causes per 100,000 of the population surveyed. The respiratory diseases head the list, and five of the eight more frequent causes of illness are serious and often fatal.[1]

[1] Falk, I.S., Rorem, C.R., Ring, M. D. The Committee on the Costs of Medical Care The University of Chicago Press 1933 P. 32



A more recent survey by the Committee on the Costs of Medical Care of the incidence of illness, determined by periodic surveys of white families in eighteen states, over a twelve months period presents the following graphic picture. In this, also, the minor respiratory diseases stand out far above any other cause.[2] It must be remembered that incidence of illness varies somewhat with age, but in another similar study it was found that the minor respiratory diseases are the principal cause of illness in every age period.

[2] Ibid., p. 33



The incidence of illness also varies with sex, occupation, season of the year, and other causes. During December, January and February the frequency of illness is almost double that of the summer months, and according to sex, there is more illness among women over fifteen years of age than among men. As for occupations, this varies so greatly according to the hazards of the industry. Generally speaking, however, it has been estimated, according to the mortality rates, that there is a greater amount of illness among the semi-skilled and unskilled workers than among the professional and skilled workers. The chief causes are accidents, tuberculosis, pneumonia and heart disease. Among those occupations where the inhalation of large quantities of dust take place, as with

coal miners, pottery workers, stone cutters, cement workers, the respiratory diseases, including tuberculosis, are most frequent. Pneumonia rates are very high among iron foundry workers and others exposed to rapid, extreme alterations in the temperature of their environment, and those working in dusty atmospheres, such as cordage and hempmill workers, polishers of iron and steel, and underground coal workers. Obviously, laborers in these industries are from the lowest social group, where there are very low standards of housing and diet, and these no doubt play an important part in morbidity and mortality statistics.

From these studies it is possible to predict in a large population unit the incidence of illness in a given period of time and the amount of preventive, diagnostic, and therapeutic medical service required. According to the findings of the Committee, the average frequency of illness is less than one per person per year. If illnesses occurred in that manner families could come nearer taking care of their own medical problems, but such is not the case. Several severe illnesses may occur among the members of one family, while another family may report no illness whatever. The following table shows the distribution of illness:[3]

[3] Sydenstricker, Edgar, "Why State Medicine Is Necessary." Free Medical Care Noble and Noble, New York City 1935

Family income class	Per cent of families in each income class	Average annual charges for medical care
Under $1,200	15.0	$49
$1,200 to $2,000	34.8	67
$2,000 to $3,000	24.6	95
$3,000 to $5,000	15.7	138
$5,000 to $10,000	7.0	249
$10,000 or more	2.9	503

With regard to families of all sizes and incomes, the study shows that 8 percent have no illness, while 7 per cent have nine or more illnesses during the year. In small families of two to four members 18 per cent have no illness, 4 per cent have six or more illnesses, and only 0.4 per cent have nine or more. Many of these families might be able to meet their burden of sickness. Among large families of eight or more, however, there are 39 per cent or nearly two-fifths who have six or more illnesses, and 15 per cent who have nine or more illnesses during the twelve months' period. The financial burden for them is obviously more than they can take care of, especially those in the low income brackets.

This incidence of illness may be presumed to occur, year after year, among a large group of people. One family may not experience the same amount of sickness one year that it has the year before, or will the year after. If one family, however, experiences nine or more illnesses in one year, several of which are of a serious nature, and if that family's income is $1,200 or less,

the financial problem is a serious one. This is not a hypothetical case--many such were found during the study. More than one-fifth of the families with incomes less than $1,200 have six or more illnesses a year, and seven per cent of them have nine or more illnesses. In the same income group, 17 per cent of the families having eight or more members have nine or more illnesses during the year.

From these studies the conclusion can be drawn that every year an appreciable proportion of all families have a very large burden of sickness. Any provision or plan for medical care would need to take into consideration not only the frequency of illness, and the various types, but also the severity of each. To insure better health, which in turn brings greater security and happiness, medical care must be provided for the most important as well as the most frequent cases of illness.

THE COST OF MEDICAL CARE

In the development of medical service during the last hundred years two lines of evolution have seemed to be converging. One is the enormous increase in medical knowledge and the great improvements in medical technique and facilities; the other is the growing demand on the part of the people for the right to health. This has created the problem of effective and economical distribution of medical service. If medical knowledge had remained the same as it was in 1860, the people could have been satisfied with regard to medical care; or if the attitudes and demands of the public had remained as they were in 1860, when the masses were trained to regard poverty as a devine discipline, there would have been no demand that some way be found to provide the improved service for all the people.

In attempting to bring these two lines of evolution together--in short, to make available to all the people the new medical knowledge, it is necessary to study the economics of the problem, and in studying the costs of medical care from the family's viewpoint it is necessary to consider the family's income as well.

The country's total medical bill, annually, is $3,647,000,000. If this were evenly divided among all

the people, each individual would pay about $30.00 annually, or each family would pay an annual charge of $123.00. If each head of a family and each single individual able to work were given the opportunity to work, and if each were fairly rewarded for his labors, this would not seem a hard burden to bear. But the distribution of wealth in the country is very uneven, making it impossible for some to pay even this small amount while others, a much smaller group, are able to pay much more than this with no financial embarrassment. A great percentage of our population have little or no surplus after paying even minimal amounts for food, clothing and shelter. In 1926, 32 per cent of New York's families received less than $2,000 a year, and this did not include those families who had no employment. If that was the situation then, how much worse it must be in these days, since the depressions.

Another factor which must be considered is that the burden of sickness falls unevenly on any given group of people. Therefore the costs of medical care, unlike the costs of food, clothing and shelter, cannot be fixed and regular, determined by the family income and its accompanying standard of living. The cost of medical care, under the present system, is entirely dependent upon the incidence of sickness and the receipt of medical care. How unevenly the incidence of sickness really is, is shown in the following table.[1]

[1] Falk, I.S. "Fundamental Facts on the Costs of Medical Care" Free Medical Care E. C. Buehler 1935

47.1 per cent have no illness
32.2 per cent have 1 illness each
13.6 per cent have 2 illnesses each
4.8 per cent have 3 illnesses each
1.6 per cent have 4 illnesses each
0.7 per cent have 5 or more ilnesses each

Every family hopes that it will escape sicknesses during the year, but no family can be certain that it will not experience the heavy burden of long or numerous illnesses.

Just as the incidence of sickness varies so do the costs of illness vary according to the kinds of illnesses, and the amounts of care needed. For a simple case of measles or a similar illness, the cost would obviously be small, but for a gall bladder operation, a ruptured appendix, or a long drawn out case of influenza and pneumonia, the cost would be many times greater. Furthermore, statistics reveal that sickness and poverty go hand in hand; those with low incomes and usually large families have the greatest percent of illness.

The Committee on the Costs of Medical Care kept records of total medical charges for a year on 1,788 families whose total annual incomes for the year were under $2000 per family. They found at the end of the period that eighty-one per cent of this group had medical bills of less than $100 for the year while 19 per cent had medical bills ranging from $100 to $2,500 for the year. The latter group would have to do one or more of several things, impair their standards of living, draw on savings, or borrow money, to pay the medical bill.

The first group, or 81 percent of the families, paid only 36 per cent of the total bill, while 19 per cent paid 64 per cent. The fact is clear that medical charges fall with great unevenness on different families during any given year.

There seems to be three reasons why the public does not receive the amount of medical care it needs--namely, ignorance, apathy and cost. By far cost is the most important, but that there are grounds for mentioning the other two seems to be evidenced by the fact that many of the wealthier class do not receive all the medical service, either curative or preventive, that they should have. This fact was disclosed in a survey of nearly 9,000 families by the Committee on the Costs of Medical Care. They made a study and formulated standards of what should be the fundamentals of good medical care. In comparing the data obtained in the survey with the formulated standards they found that neither the rich nor the poor receive medical care in the home, in the physician's office, or in the hospital, as often or as extensively as their true needs or the dictates of good medical practice warrant. However the wealthy class come nearer having the necessary care than do the middle and poorer classes. In the same study by the Committee it was found that the greater the income the more was expended for medical services.

Preventive medicine has made great advances in the last few years, and strenuous efforts have been made to educate the public regarding this important phase of medical service. It is a sad fact, however, that a very small proportion of the total costs of medical care go toward preventive medicine. Of the $30 per person spent for medical service, only $1 is spent for official and non-official public health work.

DEVELOPMENTS IN MEDICAL CARE IN THE UNITED STATES

For many years students of medical economics have been studying the problem of providing medical care, and attempting to find ways of meeting the demands and needs of the people who are not receiving adequate care. While health service must always be a personal one it would seem that in some respects an abandonment of the old tradition of "family doctor" and rugged individualism must take place in order best to serve the greater number of people, and to bring to them the new techniques and facilities of modern medicine at a cost which they are able to meet.

The American people annually pay over three billion dollars for medical care, and still many people do not receive adequate care and many physicians do not receive sufficient remuneration for their services. Many plans and solutions have been proposed and offered to attempt to solve this serious maladjustment, but it still is in the experimental stage and no definite panacea has been found. Some men feel that group health insurance is the answer; others feel that some form of tax supported medical service, compulsory for all, would be best. The Committee on the Costs of Medical Care recommended that "the costs of medical care should 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", and it would seem that this is the logical solution to paying the medical bill. Inasmuch as sickness is unpredictable, and the economic status of so many of our people is such that it is impossible to do other than provide food, clothing and shelter, it seems necessary to make some plan. Medical care is a necessity; it is a costly service and must be paid for by some means or another in all fairness to the medical profession. As a general rule people do not like to accept charity in any form, and it is a well known fact that charity lowers the morale of those accepting it, hence any method whereby the consumer or receiver pays, even in small monthly payments, is better than giving free service. The pride and self respect of the individual is preserved, and his health is protected as well.

Some plans which have been developed in the United States, and have met with a measure of success are explained in the following pages. Because conditions and situations in each community are different so are the provision of services different to best meet each particular need. But each service has endeavored to provide more or less adequate care at as reasonable a cost as is possible under given conditions.

The Clinic

Although the principal of clinic service was known and used in Europe many years before, the first clinic to be organized in the United States was in Philadelphia in 1786. There was no rapid increase in the number of clinics until after 1910; in 1926 there were over 5,000 clinics of various kinds, such as outpatient departments of medical schools; clinics in connection with special hospitals, such as tuberculosis and orthopedics; unattached clinics for general care; Federal and industrial clinics; and group clinics.

There are certain advantages in clinic service in that a larger amount of scientific equipment and more facilities for the scientific practice of medicine can be made available to many physicians. Most clinics in years past were available only to the poor, and the physicians gave their services, but in more recent years physicians have realized the value of clinics in reducing overhead expenses, and thus reducing the cost of service to the patient. People in moderate circumstances have come to like these pay clinics and appreciate the improved facilities which they afford at moderate prices. In 1922, the American Medical Association estimated that there were about eight million persons receiving care through clinics; the number is no doubt much larger in the present day.

Many clinics in recent years under either local or state government supervision have come to accept patients for certain types of treatment, such as venereal diseases and tuberculosis, without regard to their economic status. Venereal disease clinics are now maintained by most cities, and in a majority of instances, are supported by public funds. Some cities ask the patient to pay a small sum if he is able to do so, others give service entirely free to anyone applying, while others refer those able to pay to the private physicians. Tuberculosis clinics at the present time are available in most large cities to any who wish to avail themselves of this service, regardless of financial status. This is, in a large measure, due to the splendid work of the National Tuberculosis Association.

For many years county and private agencies have operated infant welfare and maternity clinics. The conditions under which they operate are similar to the venereal disease clinics. No charge is made at these clinics. In some instances prenatal care only is given, and in other cases complete delivery and post-partum service is furnished. Pre-school and school clinics, as well as dental clinics are regular procedures of many health departments. Universities also maintain clinics and give medical service, usually for a small fee, however.

The Ross-Loos Pay Clinic

An example of a pay clinic is the Roos-Loos Clinic established by a group of private physicians in Los Angelus. Their aim was to give medical service to the middle class at a price they could afford to pay.

This group began eleven years ago in an effort to solve the increasing problem of receiving reasonable returns for their services rendered. From a small beginning the clinic is now a thriving association of sixty-four doctors, thirteen separate offices and $80,000 in medical equipment. They have 19,117 subscribers, and the members or their families may have free choice of doctors from any on the staff. There is a fixed rate of $2.50 a month for a member, for which he receives medical, surgical and hospital care. The families of members pay on a fee for service basis--that is, for a subscriber's wife an office call would be 50¢ , for an ultra-violet treatment 50¢, for major operations a charge of $25.00.

There are about 200 people on the staff of the Ross-Loos Clinic, including clerks, stenographers, nurses, laboratory and Xray technicians. The doctors' salaries range from $3600 to $10,000, the minimum, $3600, being above that of the average California doctor. The establishment of this clinic aroused much controversy in the American Medical Association, and in 1935, Doctors Ross and Loos were expelled from membership, but were later reinstated, however.

Group Health Insurance

Another example of medical service is the more recent formation of the Group Health Insurance, in Washington, D.C. Twenty-five hundred government employees from the low-salaried classes secured a government grant of money, and with this they equipped a clinic and retained four doctors, seven nurses and four technicians. Complete medical service is given each individual for a fee of $2.20 a month; a family of four may receive medical care for $4.60 a month.

The District of Columbia Medical Society disapproved heartily of the establishment and threatened expulsion from the medical society of any doctor who even consulted with a Group Health physician. The staff doctors of Group Health were of course expelled. So strong was the influence of the District of Columbia Medical Society that they were able to prevent any of the Insurance doctors from practicing in any of the city's hospitals. The matter was referred to the Department of Justice, who made an investigation and gave as their opinion that such actions were in violation of the anti-trust laws in that they were the attempts of one group of physicians to prevent other qualified doctors from carrying on their calling, as well as preventing members of Group Health from selecting physicians of their own choice.

Medical Service of the Endicott Johnson Corporation

Since the Industrial Revolution large factories have come into existance, with their accompanying hazards of injury and occupational diseases. To meet this need many large industries have organized medical departments, realizing that keeping the worker fit increases his efficiency. Some have gone further and included the workmen's families in the medical service. The Endicott Johnson Corporation is an example of such a one. Their 16,000 men and their families make up a large part of the population of two towns and one city in New York State. The medical service was a gradual growth, with one physician and surgeon employed at first to give first-aid to injured workmen; later care was given to disorders not of industrial origin. The next step was when workmen asked permission to bring wife or child to the company physician. Later a small dispensary was established and subsequently the physician began attending the sick in their homes. The service has shown such beneficial results, both to the company and the workers, that it has grown continuously, increasing its staff of physicians and specialists and endeavoring to treat any and every medical condition arising from infancy to old age.

In 1923 the staff had grown to include 27 whole-time physicians, one refractionist, two nose and throat specialists, three dentists, two pharmacists, one masseur,

one X-ray technician and fifty-one trained nurses, together with necessary clerical and technical help. In each of the three towns there is a medical center, with a general office and a hospital for maternity cases. There is another building for tonsilectomies and other nose and throat work, and an isolation hospital for possible cases of anthrax. Each center has its own dental department, and two have chemical and bacteriological laboratories. A later development is convalescent homes in the country for both men and women, where the patient recovering from an operation or a serious illness may go for a few weeks or months. There is a recreational department with a director who has charge of ball grounds, swimming pools, playgrounds and various welfare activities.

Every person seeking employment with this company is given a physical examination, and if free from serious defects, is recommended for employment. A pamphlet describing the medical service of the company is given the applicant, and in six months he is re-examined. Home calls are made when necessary, and medicines and appliances are furnished without cost, as is also dental work with the exceptiong of gold and plate work. Expectant mothers are urged to come early to the company doctors for prenatal care. About eight hundred women and babies were cared for in 1922. Well-baby clinics are held each week, and tonsilectomies are performed five mornings each week.

The tuberculosis patient receives special care, and employees developing syphilis are not dismissed, but an attempt is made to cure them instead.

The cost of this service in 1922 was about $400,000, distributed as follows:[1]

Salaries of doctors, nurses and attendants	$ 198,500
Drugs and supplies	55,000
Upkeep of autos and buildings	25,000
Outside nurses, doctors, hospitals and sanitoria	120,000

Divided among 16,000 workers, each one's share is only $25.00 a year. That both the company and the workers believe the service pays is evidenced by a report from the company:

> "We have a family of happy, contented workers. They are receiving adequate medical care from doctors interested in their welfare and not influenced by financial considerations; they are not forced to consult quacks or to purchase medical nostrums; they are not impoverished by the advent of illness; they are not a burden on the charitable institutions of the community. They are therefore able to produce more finished material per worker than any similar group; they are so satisfied with working conditions that a very low labor turnover prevails; and they have had no quarrels with their employer since the business was established." (2)

1 Moore, Harry H. American Medicine and the People's Health D. Appleton and Company 1927

2 Ibid.

Health Service Under F. S. A.

Shortly after the creation of the Federal Security Administration, this agency began experimenting with medical care for its economic wards, the low-income farm families. The most recent annexation is that of 20,000 farm families in South Dakota. The agency now covers 135,000 families or about 550,000 persons.

In many Southern counties these families were organized into small "health associations" and staked to medical care with funds loaned by the Government. States now participating, having county wide projects, are Arkansas, Missouri, Mississippi, Texas, Alabama, Georgia, Ohio, Tennessee, Indiana, Oklahoma and Iowa.

In establishing an F. S. A. health project, the usual procedure is as follows: Meetings are held among families by F.S.A. officials. When the families desire to participate the F.S.A. officials meet with the medical society in the county. Written aggreements are drawn up and signed by officers of the Medical Society and the Federal Security Administration. To families who become F.S.A. borrowers, these agreements provide medical care, to physicians they assaure some degree of compensation. No doctor is forced into F. S. A. panels, and freedom of choice of physicians by families is maintained.

The government financed families pay into a common fund from $20 to $30 per year. Out of this doctors, dentists, hospitals and druggists are compensated. A family is free to choose any doctor provided he is one cooperating with the plan. The physicians usually receive payment on the basis of a prearranged fee schedule, proviced their total bills do not exceed the monthly allotments. Their schedule is scaled down one-third to one-half from average rates. Funds are first set aside for hospitalization, surgery and emergency needs. Physicians submit monthly statements to a special auditing committee appointed by the local medical association. If bills exceed the amount available the allotment is prorated among the claimants, all bills being reduced in equal ratio.

Families have been encouraged to join the medical cooperatives but are not forced to belong. They may borrow directly from the Federal Government. The loans average about $2.00 a month per family, the actual funds being placed in the hands of a special corporation in each state.

The North Dakota unit is known as the North Dakota Farmer's Mutual Aid Corporation, and is composed of one member of the state medical association, the executive secretary of the State Board of Public Health and three F.S.A. employees. Funds are allocated thus:

51% -- physicians
37% -- hospitals
8% -- dentists
4% -- drugs and supplys.

In order to participate a family must have previously received aid from the F.S.A., and must sign up for six months. Membership entitles the family to receive aid from any doctor on the list of those cooperating. In the Dakotas, over one thousand physicians are already on the panel.

California inaugerated a plan of medical care to take care of the large number of families coming from the drought areas, and for other transients, because this group could not receive free care otherwise until residents of the state one year. The corporation set up is called The Agricultural Workers' Health and Medical Association. Included in its powers are the right to borrow money from the F.S.A., to act as agent for members, become a stock-holder in any corporation, acquire real or personal property, etc.

F.S.A. officials state that physicians are pleased with the plans, because a small but steady income is assured from families previously treated gratis. Physicians counter with the reply that the societies are not satisfied, but tolerate the plans in areas where they appear to offer a solution that is better than nothing. The American Medical Association has approved of any plan whereby the Federal Government pays the medical bills of indigents.

MEDICAL INSURANCE IN EUROPE

The problem of providing medical care to people of low economic levels is not confined to one area or one country. Other nations than ours have felt the need and have experimented in forms of services. Because Europe's civilization is much older than that of the United States, perhaps, these experiments were started earlier, and have therefore been of interest to the United States as a means of helping us solve our problems.

The provision of medical service in Europe is mainly in the hands of individual practitioners, as it is in the United States. The difference is that for the mass of people the financial arrangements between physicians and patients are on the principle of group payment through some form of insurance. In some instances clinics and hospitals are used to provide medical care, in addition to group payment by insurance or taxation. Many governments in Europe have provided hospital care through taxation, supplemented in some cases by payments from sickness insurance societies to which patients belong. These hospitals are for the lower income groups. Private hospitals or nursing homes are maintained for the wealthy class who are able to pay for their medical care. The typical European hospital has a small number of physicians on the medical staff who are paid a flat salary. They

do not engage in private practice inside or outside the hospital.

In most European countries medical service for the largest part of the population is paid for in fees or regular periodic payments to a local benefit society or "fund". These societies, called "guilds" in some countries and "funds" in others, are composed of employees of a given establishment, or of all insured persons of a given locality, or of members of a fraternal or friendly society. These insurance societies are non-profit organizations, administered by officers within the society, but under government supervision. In addition to the membership dues paid by the wage earner, the employer contributes a certain amount, and in some countries there are tax fund appropriations. The money from all these sources is used to pay the expenses of medical care.

The extent of medical services varies in each country. Complete medical care of all forms is not provided in any of these insurance forms. In most of the European countries every employed person who earns less than a given amount is required by law to become a member of one of the insurance societies, and in return a specified amount of medical care must be provided. A greater scope of care may be given if the workers and the employers are willing to pay larger fees. In addition to the medical services cash benefits are given to replace loss of wages during

illness in most countries.

While there are disadvantages, as well as advantages, to these forms of health insurance in Europe, there seems to be no important opposition to the general principles of health insurance. The big outstanding feature of sickness insurance, in the experience of these countries, is that to be successful it must be made compulsory. Many of them begun as voluntary forms have later been changed by law to become compulsory, and since that has been done there seems to be unanimous agreement that the insured persons receive better medical care than they did before they were insured. There is a feeling, also, that those protected by insurance are better cared for than corresponding economic classes in countries where there is no sickness insurance.

There are some students of medical economics who feel that the insurance plan of medical care is a detriment to the advancement of socialized medicine, and do not advocate its development in the United States.

Great Britain.

The British system of health insurance began in 1911, when the National Insurance Act was passed. At the present time approximately seventy-five per cent of the population come under this act and are designated as the "insurance income group". Every person whose salary is less than £250 ($1250) is required by law to be insured, or to become a member of an Approved Society. These are the "carriers" of N.H.I., and may very in regard to benefits given, according to size and locality. When a person is accepted by an Approved Society he is given a medical card; he may then select any doctor who is on the panel, and when the doctor signs the card he is entitled to medical care. A member may change doctors whenever he wishes by going through the proper procedure. This is not a usual occurrence, however, unless a member may move from one locality to another and wish to go to a doctor nearer his work and home.

The medical service received is that within the competence of a general practitioner, and in addition the member receives a weekly cash benefit, equal to a certain per cent of his wages. Some societies pay larger cash benefits than others. There is no waiting period and no time limitation for medical benefit; the insured person is eligible to receive care when needed from the first until the last day of insurance. The services of spec-

ialists are not provided, and if necessary are arranged privately between the physician and his patient.

In addition to health insurance, each person, when he pays in his contribution pays a little more into a fund for old age pensions. He is given a card by his Approved Society, and each week he presents this card to his employer for stamping. These stamps are purchased by the employer from the Post Office, and each one represents the combined contribution of employer and employee for one week. National Health Insurance is both a compulsory and a contributary scheme. It is compulsory for almost all wage earners which comprise about one-third of the entire population, and with their dependents comprise about seventy-five to eighty per cent of the population. The contributors are the workers, the employers, and the state. The equivalent of about ten cents a week is deducted from the worker's pay, and the employer adds an equal amount. The government bears the cost of central administration, pays approximately one-sixth of the total benefits paid to insured workers, and about the same fraction of the administrative expenses of the Approved Societies and Insurance Committees.

Central administration for N.H.I. is headed by a Minister of Health, who holds a cabinet portfolio. He is a political officer and usually not a physician. Under him is an expert staff of permanent Civil servants, including an adequate medical staff. For the most part,

however, the system of operation is by the Approved Societies, which are the insurance carriers and handle the non-medical benefits, and by local Insurance Committees which administer the medical benefits.

Any licensed and qualified physician may take on an insurance practice, but is not compelled to do so. He may combine insurance with private practice, and in actual practice, many of the families of the insured become the private patients of the panel physician. Medicines are usually not dispensed by the doctor except in remote districts where there are no druggists. The patient takes the prescription to a druggist to be filled and pays no fee; the chemist forwards a copy of the prescription to the local Insurance Committee. He is allowed a set "prescribing fee", plus a reasonable profit on drugs used.

The panel physician is paid on a per-capita basis for every insured person on his panel, which amounts to 9s ($2.25) a year. He may not have occasion to see a given panel patient for one or several years, and he may see another patient every week for months. In any event the fee is the same. The average panel is about 1000 patients, and the maximum is 2500, which is common in an industrial neighborhood. It is estimated that a doctor sees, roughly, about sixty per cent of his panel patients in the course of a year. If his panel practice is not large he may combine it with private practice.

Germany

Germany was the first European country to pass a compulsory sickness insurance law, and this they did in 1883. It applied to certain industries, such as mining and railroads, which already had voluntary sickness insurance. Gradually laws were passed to extend the insurance system to other industries, as well as to increase the benefits. By 1933, about two-thirds of Germany's population were covered by sickness insurance, which had been extended to members of families of insured persons.

The benefits from health insurance in Germany are three fold. Medical benefits include the services of a general practitioner, and specialist, as well as hospital care, and to compensate for loss of wages during illness cash benefits are provided for insured members. In some parts of Germany there is close relationship between the insurance service and public health work. There are variations in the details of benefits, and in the provision of medical service. Usually the patient may choose his own doctor, but in some places a salaried physician is employed. The method of paying physicians is either according to an established fee schedule, or on a per capita basis. The specialist's services may be provided

through clinics or by arrangement with individual specialists.

The administration of insurance in Germany is for the most part by the insurance fund. In some large industries, the funds are in the hands of representatives, half of whom are elected by the employees, and half by the employers. The government, in either case, exercises supervisory control in regard to benefits and financial stability.

In addition to compulsory sickness insurance voluntary sickness insurance has been extending rapidly since the war. This is to cover persons who are above the financial limits of the compulsory system. The scope of this service differs with each group. Some are organized on a national basis, and some through commercial groups. For the wealthy class there are individual practitioners and nursing homes.

Changes in the organization of sickness insurance in operation at present in Germany are a result of the National Socialist revolution in January, 1933. According to I. S. Falk "the changes effected in the last two and one-half years have not profoundly altered either the administrative arrangements or the basic operating techniques; and with one exception (introduction of the "leadership" principle), the changes which have been made are logical outgrowths of, and are foreshadowed by, the preceding history of sickness insurance."[1]

In general the changes made in sickness insurance are the contributions of employer and employee on an equal basis, and the increase of benefits, due in part to increases in wages. Other changes effected administration by consolidation of funds, thus putting them upon a sounder financial basis.

[1] Falk, I.S. Security Against Sickness Doubleday, Doran & Company, Inc. Garden City, N.Y. 1936

Denmark

There seems to be a consensus of opinion that health insurance in Denmark, under a national voluntary system, has been more successful than in any other country of Europe. The Danish system was voluntary in so far as membership was not legally required, but there were many compulsory features--both social and economic.

The voluntary sickness insurance societies in Denmark began during the middle of the nineteenth century, but instead of following the model of Germany Denmark further developed the voluntary plan, with provisions of state subsidy for persons without means. The state passed approval and exercised supervision over such societies as were subsidized. It also aids those societies which restrict their membership to particular trades or localities, submit their records for official inspection, abide by government regulations and admit to membership any "poor" person between the ages of 14 and 40. No person is allowed to be insured in more than one society, and wives are not insured by virtue of their husband's insurance; they must be insured in their own right. Dependent children of members, under fifteen years of age, are automatically covered in respect to benefits. Government aid is given not only to manual workers but to farmers, artisans, tradespeople, and others, who may be without means.

The contributions of members vary in each locality, being dependent upon the size and scope of the benefits furnished by the societies. The essential difference is that employers do not contribute to the insurance funds; instead the state makes contributions of various kinds. By and large, state contributions have amounted to about one-fourth of the total costs.

The benefits provided in case of sickness are both cash and medical. Medical benefits include free medical attention and hospital and sanitorium care for members and dependents under fifteen years of age. Maternity benefits are prescribed for all funds and include medical attendance and in some instances cash benefits.

The Acts of May 20, 1933 made some changes in the insurance system. These new laws require that "(1) every Danish citizen is eligible to enter a fund; and (2) that every Danish citizen between the ages of 21 and 60 is bound to register with either a sickness or a continuation fund, if not already a member of one or the other, and to pay contributions as a member with dormant rights in order to maintain the right to enter a fund at a later date. Persons who fail to comply with these provisions lose their right to old-age pension and are subject to fine."[2] This makes the health insurance compulsory instead of voluntary, resulting in a large increase in membership.

[2] Ibid.

3. The service of the specialist, as compared to the service of the general practitioner, is paid for out of proportion to its value.

4. More and more, clinics, hospitals, industries, health departments, and other organized services tend, or are forced, to compete with the private practicing physician. Not infrequently the clinic or hospital physician, though interfering with a confrere's opportunity to collect a fee, gets nothing himself for the service he performs in his clinic capacity.

5. The average person in the population does not receive adequate medical service. The relatively well-to-do, as a group, can and do pay for this service, but the group is comparatively small. The indigent can obtain, in most localities, some service without cost. There remains the vast middle group, which is not and does not want to be treated by charity and yet cannot pay for adequate medical service.

6. The numbers of physicians, dentists, nurses, hospitals and similar facilities are deficient in small towns and rural areas.

7. Costs for medical care come at a time when the person is in a non-earning period, to his financial detriment and to the financial loss of physicians, nurses, and hospitals. "

It is commonly agreed, among men who have studied medical economics that there is need for better organization and coordination of medical men and facilities, but there is a difference of opinion as to what form this organization shall take. The conservative thinkers believe that adjustments must come through a process of evolution, with protection of the individualism of the physician, freedom of choice of physician by patient, no interference by laymen or government, and control in the hands of local, state and national medical soc-

ieties. Then there are others who take a more liberal or socialistic point of view. They believe that medical service should be made available to all persons through taxation or insurance, possible partial control of the medical profession, governmental supervision of the quality and amount of service rendered, and to some extent limitation of the patient's freedom of choice of physician. They hold that society, rather than the medical profession as a vested interest, must decide on how it is to obtain and pay for its medical service.

That this last point of view is gaining followers is attested to by the fact that group clinics and group insurance plans are increasing in number each year. According to Mustard, what will probably evolve in this country will be a number of different kinds of procedures for rendering medical service, varying with the localities and the problems of each. He states the points which are desirable for any scheme to cover as follows:[2]

"1. Provision of adequate medical and hospital care for any citizen or dependent who desires it.

2. A limitation of the number of families any physician might accept, the physician to be privileged, within this limitation, to decide how many families he wants this year, and next year to reduce or increase this number.

3. The physician to be entirely privileged to develop a private practice out of such families as do not choose to take advantage of the governmental provisions, or who are not referred to the physician by the administration of the service. If his private practice becomes sufficiently large or remunerative for him to drop state medical practice, he be free to do this.

[2] Ibid.

4. The patient to be able to choose his physician as in private practice, the physician, on his part, to accept or refuse the case as he would in the present arrangement, the administration to request another choice in the event the physician had his full quota of families or refused the case.

5. A provision for assignment of cases to physicians in emergencies or when patient refuses to make a choice.

6. Each physician to be required to keep proper records of all cases attended in his panel, and to serve the family on a preventive as well as a curative basis; periodic physical examinations, prophylaxis, reference to special clinics or consultants, and to keep definite records of all such services. Further, that the physician's work in panel practice be subject to review, as is now the case in hospital staff work. None of this supervision would apply to private practice.

7. Within limitations to be laid down, nursing and dental service to be supplied, and provisions for drugs, appliances, etc.

8. Payment of fees to be by government on a scale which would cause the physician to value his appointment, and thus assure, as nearly as possible, high type work by high grade men. Perhaps the fee basis for any given service might be about two-thirds of what is charged (not necessarily collected) for a similar service in a private practice fee bill. Physicians and dentists giving part time to hospitals, clinics, etc., to be compensated.

9. The costs of such service to be borne by taxation, distributed over the whole population.

10. The administration of government medical service to be under the direction of the health department."

If these points are kept in mind in a scheme of organization, both curative and preventive care would

be pretty well assured to all the population. "The health of a people," said Benjamin Disraeli, "is really the foundation upon which all their happiness and all their power as a State depend." If this be true, then it is good tactics and good policy for the state to assume leadership in this important problem.

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