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Medical care secured through fixed periodic payments

Nathaniel R. Hollister
University of Nebraska Medical Center

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Nathaniel R. Hollister

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At a time like the present no apology is needed for digressing from the usual pattern of discussing purely scienfitic subjects and embarking upon an inquiry, incomplete at best, into some of the factors which are now at work and are shaping the future nature of medical practice. Concern is not expressed for the future of scientific medicine. It is assumed on all sides that experimentation, discovery, and improvement will continue on all fronts to the same degree that they have for the last two or three centuries. It is true we can not accurately foretell exactly what form these discoveries may take. Inspiration does not lend itself to any known formula of forecast. Nonetheless we have complete faith that change for the better in scientific medicine will forge ahead in an unbroken wave. On the other hand, can we look back upon a similarly constant progressive record in the social sphere of medical practice. It is not necessary to dwell at any length on this point. It goes without saying that the most perfect scientific system of medicine which does not reach the people is as bad or worse than no medicine at all. Of course, no one will go to the point of saying that any such condition actually exists, but there is a very real controversy over whether adequate medical care is available to the people today. Argument over such a question quickly resolves itself into long winded definitions and bandying back and forth of statistics to which opponets refuse to give credence. This phase of the problem will

be taken up at a later time, and it will suffice to say at the moment that one survey, consisting of twenty-nine volumes, representing over eight years work, and over $8,000,000, has failed to satisfy the American Medical Association, who has embarked upon a survey conducted through every county medical society in the country, all seeking the answer to this one question, "Is adequate medical care available to the people under our present set up?".

There is no question that the application of medical science has failed to keep pace with the ever advancing body of scientific medicine. Social change is always slow and tedious, whereas a single discovery may completely revolutionize a whole field of scientific thinking overnight. It is not the purpose of this paper to discuss social evolution as such, but I am trying to show that medicine has become a many armed octopus, some of whose arms have reached towards the surface of the sea while others have remained embedded in the mire and entangled in the weeds of the darkest deeps. The result of any such strain on any known organism can be only catastrophic. This unequal development of all things scientific as compared to all things social is probably largely due to the fact that continued scientific advance demands only the acceptance of those scientifically minded and trained, whereas social advance requires the approval of a great mass of untutored, uncritical, and frequently very bigoted minds.

Examples to illustrate this disparity abound on every hand. The doctor today who treated his pernicious anemia, diabetes, syphilis, and mental cases in a manner similar to that in vogue

among the ancients would quickly lose face before the public. Yet that same doctor, typical of the medical profession as a whole, is distributing his skill among the people in almost exactly the same way that he did one hundred, two hundred, three hundred, or even more years ago. To those who have, he offers his services for what he can get; to those who have not, he gladly gives of such time as he can; and to those who should have but don't, he grudgingly gives as to those who have nothing. Society can always be divided into these three groups, those who have, those who have not, and those who should have but don't. The first group is capable of taking care of themselves only requiring proper education as to what their needs really are. The other extreme is a group of social derelicts who always have been and always will be a social responsibility. What they receive in any form comes as a gift, and their fortune rises and falls with social conciousness. The intermediate group is one which is numerically very large, much larger than both of the others put together. Under stress of circumstances, individuals move from it into each of the others and may return. It is the one most deserving of help and yet receiving least, it is the one most amenable to stablization and yet the most pathetic in its apparent inability to fare for itself. There are a multitude of reasons for any individual finding himself in this group: some, out of ignorance, assume burdens they can not carry; while some have these burdens thrust upon them by force of circumstance. In the first class might be placed those who through ignorance of birth control or pure cussedness create

a family they can not possibly support. In the other might be those who are normally well compensated, but whom, through the pressure of unforeseen sickness or unemployment, are not able to maintain their social equilibrium. It is immediately obvious that the solution of these problems is not a purely medical one, or up to the medical profession. They are problems of society as a whole, and the degree of responsibility varies inversely with the acceptance of the doctrine of rugged individualism.

To refuse entire responsibility for these conditions is fine, but to declaim interest is fatal. Though the decision may not be medicines to make, its form may change entirely medicines' nature, and so becomes of vital interest to those who are interested in the future of medicine.

As was said before "those who have" will always look out for themselves and quite naturally resent being dictated to in personal matters. "Those who have not" lose a large share of their social rights when they align themselves with that group and must be content with what they can get. This has always been true. But what of the middle man, "he who should have but doesn't". Such advantage as he has gained first came largely through his own effort and was wrought through organization with his fellows to wrest advantages from inclement foes, human and otherwise. Isolated examples of this appear throughout all recorded history, but from our point of view, practically started with the guild movement which dominated industrial and artisan life some three hundred to nine hundred years ago. A prominent feature of guild life was aid to

sick and injured. This has survived the present time in the form of friendly and benevolent societies. As recently as 1915, however, fewer than a million persons in England were secured against the expense of illness by any such organization. By 1904, this number had grown to almost six million persons who had of their own initiative prepared themselves for the unforeseeable expenses of illness. In a general way, those who had taken such provision were the more thrifty individuals who would be the least apt to find themselves in the class of those who "should have but didn't", leaving the majority of precarious cases unprovided for.

The propriety of this insurance principle should not be passed over without comment. Irrespective of the relation of the doctor to his patient, I think everyone will admit that it is best for the individual and society as a whole that things received should be paid for, not given. It has been demonstrated from time immemorial that there are a great many people who can't or won't make adequate provision for unpredictable expense. If by the application of the insurance principle, spreading the risk over many people and a long period of time, independence can be gained, then has not society as a whole been the gainer. No one denies the right of the individual to secure himself against a multitude of unforeseeable catastrophes ranging from twins to hail, and sickness is much more prevalent than either. The question of making such provision compulsory is decidedly more ticklish. Once the doctrine of advisability of insuring against the possibility of sickness is accepted, the belief in compulsion follows because experience has shown that those most in need of this protection are the last to

seek it while those least in need are the ones who make provision voluntarily.

It has long been remarked that Europe has been some fifty years ahead of this country in social evolution, and if application of the insurance principle to the cost of illness is any criterion, the criticism is justified. It is true that isolated instances of the provision of medical care through fixed periodic payments can be found in this country, some dating back for many years, but the concept of medical care for all those who "should have but don't" on such a basis has become an issue only in the last few years. Under these conditions, a review of European experience in this field is certainly in order.

EUROPEAN EXPERIENCE

GERMANY.

In Germany, following the Franco-Prussian War, there was a period of great social unrest. For several years, liberal social tendencies were sternly repressed by the Bismark regime, but in 1878, two successive attempts were made upon the life of Emperor William I, and even Bismark was persuaded that a conciliatory policy was in order. As a result in 1881, he introduced into the Reichstag his first bill for accident insurance which was rejected by that body. In November of the same year, he communicated to the Reichstag a letter from the Emperor urging accident, sickness, invalidity, and old age insurance. The effect of this move upon the German people was overwhelming, and in 1888, the bill for compulsory sickness insurance was passed by a large majority. Compulsory accident insurance followed in 1884 and invalidity and old age insurance in 1889. These three forms of insurance were distinct and separate entities, largely due to the fact that the employer contributes a different per cent to each scheme. This separation was maintained until 1911 when a Federal Insurance Code correlating sickness, accident, and invalidity insurance was put into effect. We are predominantly interested in sickness insurance, but it is impossible and undesirable to exclude from this discussion some mention of accident and invalidity insurance as well because they have such important medical associations.

The German Insurance Code included originally only those individuals with an income of less than 2,000 marks who were employed in mines, quarries, factories, building operations, mechanical trades, in the office of a lawyer, in establishments where steam or other motors were in use, in postal and telegraph offices, and in the administration of the army and navy. Persons in business for themselves were under no compulsion to subscribe to the system, but the previlege was theirs to do so voluntarily. It was intended originally that someday all working men would be protected.

More recent legislation has abolished the maximum wage law for industrial employees. Now all workers are included and salaried officials up to those making 6,000 marks a year may join as well.

There are a multitude of forms of insurance organization that have sprung up to relay the final provisions of the system to the people.

1. Gemeinde kranken versichierung (communal, district, or township organizations.) These are community organizations administered by township authorities whose members are made up of those compulsorily insured who do not belong to some other society.

2. Orstskrankenkassen (local sick associations.) These are the most important group, having about 40 per cent of the total membership. There is considerable elasticity in the management of these societies and much local freedom.

3. Betriebskrankenkassen (factory sick associations.) Any factory having over fifty employees can form its own society.

In some cases in which unusual risks peculiar to a single industry are present, this separation is made obligatory so as not to make other industries assume an undue burden.

4. Baukrankenkassen (building sick associations.) - for workers on roads, railways, canals, and buildings. Here again nature of working conditions often leads to unusual risks.

5. Innungskrankenkassen (guild sick associations.) - insurance offered as a part of the guild program. Guilds going into this business put themselves under government regulation and must set up a separate insurance fund.

6. Knappschaftskassen (miners' sick associations.) These clubs are of longest standing, and like the guild associations offer other inducements than just insurance.

7. Hilfkrankenkassen (free sick associations, friendly societies.) The friendly societies have, from the beginning, been activily discouraged by the government. They do not receive any benefit from employer contribution and have a set minimum benefit they must pay. In spite of adverse legislation, some of the societies manage to pay higher benefits than state backed organizations which have employer contributions and state subsidies behind them. The objection to these societies has always been the possibility of their political application.

Contributions. Of the total contributions, about two-thirds come from the workers and one-third from the employers. In some of the more progressive outfits, contributions are graded as to income, not to exceed 1½ per cent of the basic wage in communal associations

or 2-3 per cent in factory and local associations.

Benefits. Benefits are both monetary and "in kind". The cash benefit is equal to one half the basic wage, payable from the fourth day of sickness, or the day of incapacity from work if this is later than the fourth day; and not extending for a period of more than twenty-six weeks in a year. Medical benefit includes home and hospital care, including all medicines and supplies, also with a stipulation of not more than six months such service per year. In addition, is a maternity benefit of 10 marks plus sick pay for two weeks. Provision is also made for medical aid, midwife and necessary appliances. In addition, a nursing bonus equal to one half the sickness allowance for twelve weeks is offered if the mother nurses her child. Treatment in a maternity home may be substituted for the cash benefit or one half the cash benefit may be applied for home nursing service. Family maternity benefit is extended to the wife and daughters of the insured living with him. A funeral benefit equal to twenty times the basic wage is also given. Family medical benefit is an optional service. A serious limitation is that of restricting medical aid to twenty-six weeks in all cases. About one-eighth of the funds have extended this time to thirty-nine weeks and a very few to the full year.

The medical benefit includes specialist as well as a general practitioner's service. About four-fifths of the entire German medical profession work for the sick funds, and for the majority of these, insurance work is the chief source of their livelihood. Only about five per cent of German medical practitioners are engaged in

exclusively private practice.

Accident Insurance is financed entirely by contributions from the employer. All accidents whether due to the negligence of the employer or not are compensable. On the other hand, benefits are only allowed after incapacity from accident has extended beyond thirteen weeks, during which period the sufferer receives aid and care from the employer financed sickness insurance societies. The benefits, when allowed, are home medical care plus sixty-six and two-thirds per cent of yearly wage or hospital care plus relief to the dependents up to sixty per cent of wages.

Invalidity and Old Age Insurance is supported equally by employer and employee. The amount of the contribution varies with the insured's income, being graded from 1½ d. per week for incomes up to £17.10s. to 4½d. per week for incomes over £57.10s. The medical care under invalidity insurance comes in certain cases that have exhausted their twenty-six weeks of care coming under sickness insurance and who seem in a fair way of becoming permanent invalids. The main value in this work is in the preventive side especially of tuberculosis. In the years from 1889-1903, the invalidity insurance organization spent £15,500,000 for hospitals, sanatoria, convalescent homes, and sanitary dwellings.

As has been previously stated, the great majority of German doctors derive the greatest part of their income from insurance work. The method of their remuneration is up to the option of the individual insurance society. Under varying circumstances, all the following methods have been used:

1. Payment by attendance.
2. A capitation fee per insured person who the doctor engaged is to treat.
3. Same as two, except that the capitation payments are made into a pooled fund, from which the doctors are paid according to their actual attendances.
4. Payment per case of sickness attended.
5. Payment by fixed salaries.
6. Whole time doctors.

The great controversy has from the very beginning been the doctrine of the free choice of doctor by the patient. This has been approved by the societies because it reduced their bargaining power. After a struggle of many years duration, the point has finally been carried by the organized efforts of the medical profession, and one of the greatest evils of the system has been removed.

The majority of the criticisms leveled at the system are the stock points of those opposed to the insurance principle. They can be briefly enumerated, this not being the place for detailed discussion. The evil of a third party obtruding himself between the patient and the doctor is stressed. It is claimed that insurance undermines manliness, encourages effeminacy, cultivation of bodily ailments, and moral deterioration. It is claimed that the sick person does not really get his just deserts. The assertion that the public health is improved is difficult of proof and is a favorite bone of contention.

The ultimate test of the value of any system of health

insurance lies in the answer to two questions: are the cash benefits adequate, and is the medical service adequate. In a system such as Germany's, where there is so much variation between the local funds and the services they offer, the answer to both questions must be yes and no.

In the matter of cash benefits, it is true that even those in the lowest income brackets receive benefits in proportion to their basic wage. But it is quite obvious that a family normally budgeting on $2.00-$3.00 a week will be running with a much narrower margin of safety than one running on $7.50-$8.00 a week. In the latter instance, $3.75-$4.00 as a cash benefit may be an adequate amount for subsistance requirements, whereas a benefit of $1.00-$1.50 in the first instance will almost surely be grossly inadequate. Thus it seems that the benefit is sufficient for one extreme and grossly insufficient for the very lowest income group among whom the incidence of disease is the highest.

In the matter of medical benefits, a similar disparity exists. Due to the various planes upon which groups are divided into various funds, it is inevitable that some funds will be made up of a larger number of higher salaried workers while others, particularly in the rural areas, are predominantly lower salaried workers. This results inevitably in a great variation in the surplus the fund is able to gather for the benefit of its members. Since the cash benefits are set at an irretractable minimum by statute, the poorer funds must economize in other ways, which means at the expense of the value of the medical benefit. Thus we find that while

the more affluent funds are able to set aside $1.76 for medical treatment, $1.09 for medicine, and $1.75 for hospital treatment per member; the more hard pressed funds offer $.92 for medical treatment, $.50 for medicine, and $.40 for hospital treatment. Assuming that the adequacy of medical care of the better paid workers is at or near the margin, that of the lower brackets is hopelessly substandard.

ENGLAND

Whereas Germany entered the field of national health insurance as the pioneer, England had the experience of twenty-eight years actual practice in Germany as a guide before they even drafted the bill. It is difficult to point to any one precipitating factor which can be given either the credit or the blame for the presentation and passage of the National Insurance Act. Undoubtedly one of the most important was the effect of the Royal Commission on the Poor Law which appeared in 1909. This commission, with a total budget of over £52,000, over a period of two or three years gathered material upon the administration of the Poor Law and upon the condition of medical care for the under privileged. They submitted both a majority and a minority report, neither of which actually recommended compulsory national insurance, but both of which stressed the inadequacy of medical care available to working men and indigents.

Lloyd George, then Chancellor of the Exchequer, is credited with the principal role as author and sponsor of the bill,

and conservative criticism has always maintained that the primary purpose of the whole scheme was political rather than social. Even at this date, it is hard to actually assess the motives of the sponsors, so everyone is free to believe as his conscience dictates.

In any event, even though the measure was hurried through Parliament in record time, there has been quite careful study of German experience, and many fundamental differences existed between the original English bill and the German law in force at the same time. This difference was in no small part due to the fact that while the German Imperial Government was in a position to dictate the provisions of its act, the British Government had to effect a series of compromises with interested parties. On the one hand were the Friendly Societies and Trade Unions who had offered sickness benefits for many years, and upon the other had was the medical profession which was in mortal fear for its future existence.

The concern of the medical profession was not without some justification. They had for years been at the mercy of the bargaining power of the unrestricted Friendly Societies who had used their size and assured income as a club to beat down cost of medical service. The medical profession was determined on one point, that being that the medical benefit should not be administered through these same Friendly Societies that had been throttling them for years. To this end, petitions were circulated, and almost fifty thousand signers were secured who promised to refuse medical aid if that function were to be conducted by the Friendly Societies.

Their point was carried and a dual system was established with the old Friendly Societies, now Approved Societies, handling the cash benefit, while the medical benefit was under the control of Local Insurance Committees. These committees were to be composed of three-fifths representatives of the insured, one-fifth appointed by the county council, and one-fifth representing the medical profession. As the system has developed, these committees have not realized their fundamental purpose. The British Medical Association quickly assumed the role of arbitrator between the Insurance Companies and the doctors on a national scale, and the Insurance Committees have been left with only purely local problems of administration. They keep complete records of all insured persons, price prescriptions (a yearly expenditure of £9,000,000), receive complaints, and so forth. The cost of such local administration amounts to 5 per cent of the total cost of the medical benefit and is one which could be largely eradicated. In fact, a Royal Commission reporting on Health Insurance in 1926 recommended that these bodies be disbanded and their remaining duties be assigned to a committee appointed by the county or borough council.

The Approved Societies have not developed in exactly the manner expected and hoped for by those who planned the scheme. Under the old system of voluntary insurance the units were relatively small and largely local in distribution. The more thrifty workers were the ones insured, and there was a very strong spirit of loyalty to the fund, so that fradulent claims were at a minimum.

When the new system was enacted, the old Friendly Societies were retained, and it was hoped that similar organizations would be organized to take care of the influx of insured persons. The commercial insurance companies, feeling that their position as life insurers alone would be endangered, quickly organized divisions or branches on a non profit basis to cover themselves. These outfits were organized on a national basis with little regard for local conditions, local voice not being of sufficient magnitude to be heard in the distant London offices. As a result, we find that 65 per cent of the societies have 2 per cent of the business while 2.5 per cent of the societies have 76 per cent of the business. Organization on such a grand scale immediately removes any of the club spirit on the part of the individual insured and further leads to a concentration of wealth and power which has become an alarming force.

Another result of this form of organization is that there is tremendous overlap in coverage by the various societies resulting in a much greater expense for administration than is necessary. This is a strong argument in favor of a single national society which would reduce unnecessary duplication to a minimum. This would have another very desirable effect, in that, with a single company of national coverage, it would be possible to compile national and local morbidity statistics which would materially help in indicating local conditions predisposing to sickness and also in the detection of over certification and malingering.

Contributions are basic in the case of men, four-ninths

by the insured, three-ninths by the employers, and two-ninths by the government. In the case of women, three-eighths by the insured, three-eighths by the employers, and two-eighths by the government. This is the standard for workers making over $.62 a day. As wages fall below $.62, the relative contribution of the insured falls while that of the employer rises. Thus for wages above $.62, the worker pays $.08 weekly, the employer $.06, and the government $.04. As the wages fall below $.62, the worker's contribution falls to $.06 weekly, the government's stays at $.04, while the employer's rises from $.06 to $.08. When wages reach $.50, the worker pays $.02, the government $.06, and the employer $.10. Where wages fall below $.37, the insured pays nothing, the government pays $.06, and the employer $.12.

This scale shows several fundamental changes from the German system. In the first place, the idea that the Government should aid is here accepted. In the second place, the contribution of women is set at a lower rate than for men. The workers contribution never equals one half of the total contribution, whereas in the German system, it is always two-thirds. Also as the wage falls, the contribution of the worker decreases in proportion while that of the employer increases, until in extremely low wage groups, the worker contributes nothing and the employer pays the lion's share.

Benefits Peculiarly enough the cash benefit is a flat payment of $2.50 per week for men and $1.87 per week for women regardless of the size of their contributions. This is payable for a period of twenty-six weeks after which further incapacity is

compensated by the disablement benefit which is one half of the sickness benefit. This is payable only in cases of total disability for any work and continues until the age of sixty-five when the old age pension picks up the burden. It was originally intended that both the medical and the cash benefit would be administered by the same body, namely the Approved Societies. It has already been shown how this plan was spiked by the medical profession, and how the Insurance Committee came into being. Any licensed practitioner has the privilege of entering his name with the local Insurance Committee as being ready to treat panel patients. From that point on, his success depends upon his ability to draw panel patients to him. Under the law, he may have a panel of up to fifteen hundred members. It should be remembered that these panel members are all wage earners. Dependents of wage earners are not included in the plan. In the normal course of events, the dependents of an insured will go to his panel doctor as private patients. Since the average insured worker has one and five-tenths dependents, a full panel of fifteen hundred members means a total practice of three thousand seven hundred and fifty patients. Of course, in any given year, all of these people will not consult the doctor, but this gives some idea of how the system works. We have already seen how the employee pays his share of the expenses, a check off from his wages. On the other side of the fence, the doctor is paid a capitation fee of 9 s. per panel member per year. For this sum, he contracts to give general practitioner service to the members of his panel. This figure of 9 s.

was not arrived at without considerable bickering. The figure in the original bill was set at 6 s., but the very vigorous patients of the medical profession raised the figure to 7 s. 6 d., and as a result of post-war devaluations of currency, the figure was finnally raised to 9 s.

The service that is offered to panel members is not clearly established by definition. The matter is stated in rather indefinite terms as, "the service shall consist of a kind which can consistently with the best interests of the patient be properly undertaken by a practitioner of ordinary competence and skill". The actual decision of what shall and shall not be included is a result of usage and decisions of the Insurance Commissioners. A short list of decisions may be of interest.

Ruled to be within the doctor's obligations:

1. Fracture of leg.
2. Curretting of uterus.
3. Reduction of dislocated elbow under anesthetic.
4. Removal of needle from foot.
5. Taking blood for Wassermann Test.
6. Vaccination.

Ruled to be outside the doctor's obligations:

1. Passage of Eustachian Catheter.
2. Intravenous injection of novarsenobillon.
3. Removal of tuberculous glands from neck.
4. Application of radiant heat and ionization.
5. Removal of appendix.

6. General anesthetic for tonsilectomy.

7. Operation for hemorrhoids.

8. Testing eyes for refraction.

Care of maternity cases is not included among the doctor's obligations, or is any condition arising as a result of the labor. In some instances, a doctor may be qualified to render services above the level of the general practitioner. In such cases, he is entitled to recover from the insured for such special service, the decision as to the propriety of the charge lying with the local Insurance Committee. This involves a degree of red tape which is discouraging to the practitioner since the approval of the Insurance Committee is supposed to be secured before the procedure is undertaken.

Something has already been said about the remuneration of the doctor. The average panel in England and Wales consists of nine hundred and thirty members. A panel of one thousand carries a yearly income of £450 (about $2,250). There is no expense for drugs, but the doctor does have to maintain his surgery. It will be remembered that the original bill called for a capitation of 6 s. and that 9 s. was the figure finally settled upon. This increase in medical cost above that expected resulted in curtailment of other expenses, one of the first to be effected being the medical benefit. In short, there is nothing left over to pay for special procedures or special services. So while the doctors have materially advanced their own financial standing, it has been at the expense of the service available to the insured. This remains

one of the principal faults in the whole situation, a fact recognized by all, and it seems quite likely that in the near future the system will be extended to include special services, but not without additional revenue.

The two most pressing difficulties which arise from human failure rather than defect in the system are over prescription of drugs and over certification of disability.

Over prescription is evident in three forms. In the first place, the doctor may prescribe to cover his own ignorance or to escape a lengthy discussion with the patient. In the second place, some doctors insist on using the latest preparations, proprietary and otherwise, before they are accepted by the medical profession. And in the third place, in some cases of malnutrition, special foods, vitamins and so forth, are perhaps indicated, but it is questionable whether the drug fund can be expected to stand the gaff of making up the deficiency in the family larders. Issuance of a national formulary has helped somewhat in curtailing these practices, but the major blame rests with the medical profession.

That there has been undue certification of disability, there is no question. From 1921 to 1927, the claims for disability among married women have increased 100 per cent, of unmarried women 75 per cent, and men 64 per cent. That there has been any such increase in sickness is unbelievable. Closely allied to these findings is the work of the Regional Medical officers. There are fifty-nine such officials on the staff of the Ministry of Health

whose main function is reviewing cases of doubtful incapacity. In 1927, 312,580 cases were called for review because of doubted incapacity. Of these, 135,829 failed to appear for examination; 176,751 attended, of whom 50,951 were found perfectly capable of work. These figures speak for themselves. The only thing that is not apparent is why so many present day medical writers seize upon these statistics to condemn health insurance, when in reality, they are the most damning evidence that could possible be brought against the medical profession itself because it shows direct collusion between the insured and the doctor or at least the willingness of the doctor to compromise his ideals for the immediate favor of the patient.

DENMARK

It has become the fashion to consider with some awe the achievement of the Scandanavian Countries in matter of social experiment and progress. Denmark shares the unique honor with Sweden of being one of the only two countries in Europe with a system of Voluntary Health Insurance on anything approaching a national scale. The question of complusion has long been a bug-a-boo in any discussion of health insurance in this country; so it would be well to give some consideration to a plan which is voluntary. Denmark had for years been strongly organized under the guild system, until in 1863, the government took active steps to break the guild monopoly. After this time, health insurance was continued through free associations which were organized along trade union lines and

ideals. As these associations increased in membership and extended from strictly urban to rural distribution as well, a gradual change toward strictly local control took place. In spite of considerable numerical growth, it was predominantly the higher paid workers who were insured. For this there were at least two reasons. The more capable were the ones who recognized the value of the insurance, and the more highly paid were better able to meet the premiums. Recognizing this fundamental shortcoming in the scheme, the fact that those most needing protection were not getting it, the Government entered the field in 1892 with the object of extending the benefits of health insurance to the lower income groups.

To the existing insurance carriers, they offered cash subsidies of about one-third of their revenue in return for a certain amount of government regulation. In addition, they made avaliable hospitalization for insured persons at reduced rates in government hospitals. The regulation imposed was largely in direction of graded premiums so that the lower income groups actually paid less in premiums than the real cost of the medical attendance they received. The government subsidy was calculated to cover this shortage. The increase in membership under this regime has been considerable. Thus in 1893, 7.9 per cent of the working population was insured, whereas in 1928, this figure had grown to 65 per cent, comparing favorably with countries having compulsory insurance plans. It would be well here to say more on this point of volition in the Danish plan since this is one of the things most fre-

quently remarked about it. It is the law in Denmark that anyone who is the recipient of government relief shall be deprived of his vote until such time as his debt is repaid. Also he can marry only with the consent of the authorities and forfeits his right to an old age pension if he has had relief within the preceding three years. Since sickness is one of the most potent causes of total or partial indigency, very strong moral pressure is brought to bear upon each individual to insure himself. This is quite a nice idea for we Americans to consider, as it would not take long to put the skids under the "New Deal" if the W. P. A. was removed from the voters list.

A fair idea of the working of the plan can be gained from consideration of the Familosygekassen in Fredrikshouen. Anyone having an income of less than 3,800 kroner and a total fortune of less than 11,700 kroner if single or 16,800 kroner if he has dependents (18 kroner equals 1 pound) may join this society. Sixty per cent of the entire population belongs to this one society and 97 per cent belong to some government approved society. Premiums and cash benefits are both graded according to income, being over fifteen times as large for the highest income group as for the lowest. Thus this system lies midway between the English and the German, they recognize the importance of radically scaled premiums but do not accept the total responsibility for the lowest income group. Since the largest per cent of insured fall in the income group whose payments are less than they as a group receive, the annual deficit is considerable, in this case amounting to about 27,500

kroner, about 95 per cent of which is met by the government.

The position of the doctors under the Danish plan is dependent upon individual contracts between local practitioners and the insurance carriers. It is seen from the English experience that this is apt to lead to unbearable chiseling on the part of the insurance companies. In the instance of the society mentioned, a capitation system is used, a payment of 4.20 kroner per year per member being made to the doctor, the doctor's income being 20,000 to 30,000 kroner per year. That more dissension has not taken place on the part of the medical profession is a tribute to the fairness of the insurance companies and serves to illustrate what seems to me a very important factor, namely that difficulties which may be insurmountable in a country of 50,000,000 inhabitants or more are more easily ironed out in a small country of less than 5,000,000 in habitants. Another fact of interest is that there is freedom of choice of doctor only among those who are in the employee of the society carrying the insurance. A total of from 70-75 per cent of medical practitioners do insurance work. Originally the service was intended to cover only general practitioner service, but this has been extended to include specialist service where specialists are available. In the end, it comes out that the societies in the larger cities, as in Germany, offer a much more complete service than is available in the more outlying districts.

It has already been stated that hospital care for from thirteen to twenty-six weeks per year is available without additional cost to the insured. This is made possible through the granting

of special rates to the insurance societies, whereas the actual cost of hospital care may be 10 kroner per day, the insurance societies never pay over 2 kroner. The whole hospital scheme is entirely foreign to our experience. All hospitals are either municipal or district institutions directly under the government so that any defecit that they run falls on the local or the national government. The staffs of these institutions are mostly full time state employees, so that the general practitioner does not follow his patients into the hospital. Although complete reports of hospital management are sent to the referring doctor, this is a system which would be wholeheartedly condemned in this country.

Another interesting departure in this system is the division of the insured into two classes at the time they join an approved society: those who are in good health, and those who are suffering from chronic disease. The records for the latter group are kept separately and any expense they run over the average for the originally healthy group is made up by the municipal and national governments.

Persons in income groups above those specified may form voluntary insurance societies, but they have none of the multitude of government subsidies which have been enumerated.

In 1921, the total expenditure for health insurance amounted to over 30,000,000 kroner. Of this 14,3 per cent went in cash benefits, 2.2 per cent to women in confinement, 12.9 per cent in hospital treatment and convalescent homes, 45.4 per cent in medical treatment, and 11.9 per cent in administration.

In 1921, an act providing for invalidity insurance was passed. All members of sick benefit clubs between ages of fourteen and forty pay a sum of 5 kroner 40 ore per year into the fund. The employee pays a similar amount, and the deficit is met half by local and half by national government. The benefit consists of an annuity of 540 kroner per year which in severe cases may be raised to 800 kroner by special grant from the municipalities. Disability is defined as reduction in working capacity by at least two-thirds.

In summary, it may be said that the medical service is probably adequate, varying in caliber from rural to urban surroundings. On the other hand, the cash benefit is grossly inadequate to make up for the loss of earning power due to sickness. This is the price which has been paid for the inclusion of the lowest income groups on a contributing basis.

SWEDEN

Here as in Denmark sickness insurance is voluntary rather than compulsory, but at this point the resemblance between the two ceases abruptly. The Swedish system is based on the principle of monetary benefits only, so does not come under the heading of medcal care secured through fixed periodic payments. The relation between the doctor and the patient is the same as it has always been, the patient paying regular fees if he has the money. There is complete separation between the various types of social insurance, each having been adapted at a different time than the others,

and state recognition of sickness insurance is one of the most recent changes. Voluntary, completely uncontrolled sickness insurance had been present for many years, just as was true in most other European countries. Beginning with an Act in 1910, a series of government bills extending subsidies to insurance carriers have been put into effect, until by 1921, the following were in force:

1. 2 Kroner per member per annum.
2. 25 Ore ($\frac{1}{4}$ kroner) for each day of incapacity, excluding Sunday, during which the society has paid during the preceeding year at least 90 ore, or has maintained the patient in a hospital.
3. An allowance of one-fourth of the cost of medical and pharmaceutical expenditure for insured persons during the ensuing year, subject to maximum limitation.
4. When maternity is the subject of insurance, and the sickness society pays for not less than fourteen days, either 90 ore a day, or bears the expense of the insured in a maternity home, and when the patient also is insured against sickness, the Government pays 60 ore for each day during which the society has paid maternity benefit.

These subsidies are all from the national government, the question of subsidies from local government being up to local option entirely. This is also true of contributions on the part of the employer.

I have not been able to find sufficient material to adequately cover the Swedish system, but comparison with other systems cast serious doubt upon the adequacy of a system which must depend to such a large degree upon the payments of the insured themselves. In the English and German systems, a very substantial proportion of the insurance income is paid by the employer as well as a government subsidy fairly comparable to that of the Swedish Government. In spite of this, there is still not enough to take care of cash and medical benefits as amply as many critics wish. How, therefore, a system based largely on employee contributions can adequately cover the same field does not seem possible, unless there is no marginal class such as is present in every other country we know anything about.

NORWAY

Sickness insurance has been compulsory in Norway since 1911, the same year that England adopted a similar act. It covers all workers, manual and otherwise, whose incomes are less than 5,200 kroner. This includes about 23 per cent of the population directly, but increases to about 55 per cent when you add the dependents of the insured who also receive care.

The expense of insurance is carried mainly by the insured (six-tenths), the employer and the community each contribute one-tenth, while the state contributes two-tenths. There does not seem to be a sliding scale with increased employer contribution for workers receiving sub-marginal wages. The insurance is carried by

private carriers, but only one company is allowed in each district and that company handles sickness and invalidity insurance and old age pensions. That this effects a real saving is shown by the fact that the cost of administration here is only 8.5 per cent, whereas Denmark, a small country noted for its frugality, shows that administration expenses amount to 12 per cent of total cost.

Sickness benefit begins after three days incapacity for work and amounts to 60 per cent of the average daily earnings. In 1924, each insured person had 9.84 days of sickness, including the first three uncompensated days.

The medical benefit is quite complete including dental extractions, specialist service, and some special appliances. In addition, the wife and children under the age of 15 are eligible for the medical benefit. Drugs are not included as an item in the medical benefit, and must be secured by the insured. Thus the insured acts as a check upon overprescription, removing much of the possibility of the medicine drinking habit. The doctors in Norway consider this a condition of prime importance, and say that if drugs were to be included in the medical benefit, they would have to raise their fee schedule 25 per cent.

The method of payment to the doctor is quite unique here. The doctor is paid as he has always been, by the individual who gets a signed voucher from the doctor. He then turns this voucher over to the insurance company and recovers his money. The average cost of this service per insured person in 1928 was 14.2 kroner. Compared to the cost in England this would be 16 s. compared to

the English figure of 9 s., but the Norwegian figure includes treatment for the insured's dependents.

So here we have a system which maintains absolute free choice of doctor, controls overprescription, gives adequate medical care to the insured and his dependents, and suckles the sacred cow of payment per visit rather than payment of a flat rate. On the other hand, there is no special provision made for the submarginal wage earner who really needs 100 per cent of his earnings while sick, whereas his more fortunate brother who makes a more substantial wage can string along on 60 per cent of his wage without facing actual want.

THE NETHERLANDS

Sickness insurance here is entirely voluntary and is offered by all the different types of societies that have been mentioned in any of the other countries. The Netherlands were one of the Guild strongholds, and many of these funds are direct holdovers from those days. This relationship is shown by some of their names, such as: "The Linen Weaver's Fund", "St. Michail's" or "The Broom-maker's Fund", and "St. Crispin's", or "The Shoemaker's Fund".

In most of the insurance societies, dependents are not insured, but an individual will not be taken unless he also insures his dependents. Subscriptions cost from .3 to .5 guilder (1 guilder equals 1 s. 8 d.) per week, and in some cases, may be deducted from wages. There is no other source of income. The employer and the

government do not participate. The benefit is only medical, no cash income during sickness. The surplus, if any, may be distributed as special services or may be divided among the doctors.

There is no free choice of doctor outside those employed by the individual society. Thus in a very large one, the choice would be wide; whereas in a small one, the choice would be quite restricted.

The doctors are in most cases employed by the insurance funds, a system fraught with potential evil.

So, according to all the standards we have set up, this is a grossly inadequate system. In the first place, there is no cash income during sickness. There is no uniformity of service or cost and much dual coverage leading to an unnecessary high cost of service. There is no free choice of doctor, and the conditions of medical employment are bad. So, other than the fact that it is voluntary which is a qualification of doubtful value, this is a very incomplete and inadequate service.

FRANCE

France is a relatively new convert to the idea of compulsory national health insurance. For a great many years, voluntary insurance had been available. Some 19,000 societies offered insurance which had been taken out by over four million persons in 1924. These organizations were fraught with the evils we have, heretofore, attached to almost all the voluntary systems. The doctors had to bargain with insurance societies as best they

could, and they usually came out on the short end of the horn. Also the encouragement of preventive medicine was nil, and this is a factor much stressed in all modern health insurance schemes. It should, in fairness, be said that the mere talking about the importance of the preventive aspect does not insure its application. The question is thrown up on all sides, and as far as I know there is no answer available. When one considers the notorious inaccuracy of comparing mortality and morbidity statistics from country to country, it is hard to accept the statement of either side as to whether national health has been improved or not under any of the existing plans.

The interest in compulsory health insurance in France has been a post-war development, and by many has been attributed to the presence of Alsace and Lorraine within the French Republic. A technical commission reported on the subject in 1919 and the Minister of Labor introduced the first bill in 1921. The final bill was passed in 1928, and it is of interest to note that at no time during the entire period that the bill was pending was there any conference between the Senate and any official body of the medical profession with regard to the relation of the profession to the proposed legislation.

The general plan is very similar to those that have already been discussed. A definite salary limit, higher for those with dependents, is set, and any below that limit are compulsorily insured. The government feels that they have discharged their responsibility when they provide care for the indigent, so the

cost of the contributory insurance is evenly divided between the employer and the employee. Benefits are both monetary and "in kind". The cash benefit is one half the wage, and the medical benefit is complete care including hospitals and drugs. This is gained by a payment of 5 per cent of the total wage by the worker and 5 per cent by the employer. This payment insures against the risk of sickness, old age, maternity, death, invalidity, and unemployment. The medical benefit is extended to the wife of the insured and to his children under sixteen years of age.

Thus in this system, there is complete coverage for all conditions and hospitalization as well. This is a distinct advantage over the restricted service offered by the English plan. On the other hand, there is no gradation of the amount of the workers contribution in cases of very low wages, and since the cash benefit is one half the wage in all cases, it will of necessity be inadequate in marginal cases. The plan to extend medical care to dependents is admirable. So the main criticism remaining is the justification of taking as large a per cent of the contribution from the very low wage group, and the fact that the cash benefit must be inadequate for those receiving one half of what was originally at a marginal subsistance level.

The doctors have protected themselves somewhat by organization and are thus able to minimize the evil of direct bargaining between the doctor and the insurance carrier.

A great deal has been written and said about the doctor-

patient relationship under health insurance, in fact, this point is one of the principal ones used by critics of health insurance which obtrudes a third party between the doctor and his patient. In view of this fact, it is interesting to note some of the statements of French writers on this point.

Professor Barthelemy has said that medical secrecy paralyzes justice. While Dr. Rist states that the doctrine of absolute medical secrecy supplies a means of escaping cases of conscience, of declining responsibility, and of washing ones' hands of the most obvious duties. It may seem unfair to present statements upon only one side of such a controversial question, but I am sure everyone has heard statements supporting absolute medical secrecy reiterated over and over again, so that further repetition would almost amount to insult. I think that these two statements might well give rise to some healthy thought upon this question. Along this same line, it was pointed out in the American Foundation study on American Medicine that perhaps the importance of the confidential doctor-patient relationship was of far more interest to the doctor than to the patient. A local example of this very point is the number of patients who feel that the impersonal clinic service of the Mayo Foundation is preferable to the personal touch of the old family physician. This is a fact we have heard repeated an untold number of times by members of our own faculty. One is forced to wonder if at times the medical profession is not closely akin to the ostrich with his head buried in a handy sand-bank.

EARLY AMERICAN EXPERIENCE

Despite the fact that it is little appreciated, actually medical care supplied through fixed periodic payments is not at all a new institution in this country. In certain isolated industrial enterprises, various medical benefit plans were evolved largely as the result of the nature of employment in these industries. This statement applies particularly to the railroad, lumbering, and mining industries. That this statement is true is adequately proven by the fact that the various state workmen's compensation laws which have been enacted since 1911 specifically state that industries having already made adequate provision for the care of accident and illness attendant to employment shall be allowed to continue their own plans without alteration. The experience of the railroad industry has been unique due to the fact that workers employed in interstate commerce have never been provided for by legislative means, so that many plans for their care, even today, are the result of the evolution of employer and trade union cooperation. In all other industries, there has been a very close tie up between the evolution of workmen's compensation legislation and industrial employee fixed payment medical service.

It is interesting to note that of twenty-seven trunk line railroads having hospital associations twenty are roads operating west out of Chicago or had all their track west of the Mississippi River. Only seven are on roads operating east of Chicago. It has already been stated the employees in interstate

commerce are not covered in any way by existing state workmen's compensation laws. The only way these employees may be cared for through legislative means is by and act of Congress. In the session of 1911-1912, a federal workmen's compensation law designed for this very purpose was introduced in both Houses of Congress and was finally passed by both. However, certain amendments were not agreed upon by both Houses and the issues were not decided at the time of adjournment. Unfortunately the matter has never been taken up again.

Despite the lack of legislation dictating such policy, many of the railroads have accepted the responsibility for injury and illness arising as a result of employment; so that in the majority of these railroad hospitalization plans, the employer's contribution is calculated to cover the expense arising from disability due to employment while the employee carries the burden for all other illness.

On almost all railroads that have hospital associations, membership is automatic, all employees being members. Receipt of benefits, however, is only for current employees; and so, except in a few definite exceptions, a layed off employee looses his right to benefit. This is an important consideration in the present state of unemployment and indicates a definite short coming in plans of this kind. The dues are in the form of monthly payments usually collected as a "check off" from wages. They are usually a fixed per cent of the wage, around 1 per cent, although there is a considerable variation in this matter. The benefits are almost ex-

clusively medical in nature, only two out of twenty-seven plans studied making any cash payment. The medical benefit is in the form of complete medical care for the worker, including hospitalization, specialist service, and so forth. These same services may be available to the worker's dependents at a reduced rate. It might be of interest to inject here a note on purely local experience. One of our own railroads has for many years had a hospital department which provides complete domicilary and hospital care to workers at a monthly cost of $.75 for each laborer. For a short time a few years ago, this railroad subscribed to a group insurance policy designed to pay to workers two-thirds of their weekly wage during illness incapacitating them for one week or more. This was done at no cost to the workers. The result was that trivial illnesses were extended to a week's vacation, and when time for renewal came, the insurance company asked a higher premium. The insurance was dropped. This is a homely local example of one of the greatest difficulties in the administration of a health insurance set up. This is a problem which has been troubling the English authorities for over twenty-five years. It clearly shows that individuals not intelligent enough to provide for themselves will try to take advantage of improvements that are given or thrust upon them. The question of who shall check this abuse is a sore one, but logically the doctor can not escape the fact that he is the one best qualified to decide whether a given individual is able to return to work or not. This is an unpleasant duty, and from the shirking of it, much of the justified criticism of health insurance schemes has

arisen. Another point gained from local experience is this: the dependents of railroad workers are not provided for, and yet in actual practice, there is a very strong tendency on the part of employees to consider the company doctor obligated to give service without their acknowledging any comparable obligation to pay for such service. This leads to a state of friction, and the company doctor frequently feels that it is easier to give the service than to have trouble all the time. I have not seen any mention of similar difficulty in England, where a like situation exists, but it would be surprising if such niggardliness were a purely local characteristic.

No small part of the doctor's wish to allay difficulty arising from the insecurity of his employment. The conditions of such employment vary all the way from full time staff to consultation on individual cases, and include in various schemes all varieties of part time service. In all cases, however, the doctor is employed by a corporation which has few scruples about letting him go if it is convenient. This also allows very limited choice of physician by the patient. In short, the working of the plan depends upon the management. If they are benevolently disposed, things will run smoothly; if not, then the doctor's position is anything but enviable and the patient is lucky with what he can get.

The State of Washington has the honor of being the first state to pass a workmen's compensation law. This was accomplished in 1911. Unfortunately the original bill was passed without any provision for medical aid, so the benefit derived was entirely

monetary. This arrangment was clearly inadequate, and finally in 1917, a Medical Aid Act was passed providing medical care. The expenses for such care were to be borne equally by the worker and the employer. There are two available plans, each having full approval. The state plan calls for equal contribution by worker and employer, the whole amount being turned over by the employer to the State Medical Aid Fund. The worker has complete choice of physician and hospital, the employer furnishes transportation to place of treatment, and all the bills are paid from the state fund upon approval by the State Medical Aid Board. If, on the other hand, the employer has the consent of at least half his workers, he may elect the contract rather than the state plan. In such case, the employer contracts with a hospital, hospital association, or group of doctors, to provide medical and hospital care for his employees. The employer keeps 90 per cent of the total contribution to cover the cost of the medical aid contract and sends only the remaining 10 per cent to the State Medical Aid Fund.

Neither the state nor the contract plan profess to do more than provide medical care for industrial, that is compensable, injury. During recent years especially, there has been a growing tendency to contract for medical care for non-industrial illness and disability. The cost for this falls directly upon the worker himself, the payments usually being deducted from wages and paid directly by the company to the same professional service organization that takes care of compensation medical work for that company. Thus in any case where complete coverage is secured, two medical

service contracts exist, one, the medical aid contract, for industrial accident; and the other, the medical service contract, for non-industrial illness.

In general all the various plans may be reduced to a common formula. The employer and employee each pay an equal amount toward the state medical aid fund. This amounts to about $.03 cents a day for each one. The payment for non-industrial illness is made by a "check off" from the workers' wages. This usually amounts to about $1.00 a month. In a limited number of instances, the worker can secure medical care for his dependents by payment of an additional premium of from $1.00 to $1.50. However, except in special instances where the employer owns the hospital himself, the medical care for dependents is domiciliary only, and hospital bills for dependents of workers must be paid in full by the worker.

In 1929, approximately 47,000 wage earners were entitled to complete coverage service by existing contracts and there is no doubt that the system is rapidly spreading. There is some question in the minds of some that this is a desirable thing. There does not seem to be any doubt that the quality of service demanded in industrial compensation is the very best. The work is carefully supervised, and the State Insurance Commission can withhold payment for work improperly done or may remove a patient from the care of a given doctor if proper treatment is not being given. It has been stated that the degree of supervision and so forth has robbed compensation work of its profits and that the

doctors have been driven to contract practice to protect themselves.

Experience in Oregon has been very similar to that in Washington. Some of the defects not already pointed out can be discussed in the light of Oregon experience. It turns out that most of the contract agreements are made with a few large associations operating over the entire state, or even in other states as well. The fees that they pay are very much lower than those gotten for regular private work, and the serious and unusual cases are taken to the association headquarters for treatment. So the local doctor is reduced to a sort of first aid practitioner for which the remuneration is quite slim. A method of combating these evils has been the organization of groups of practitioners to assume responsibility for industrial contracts rather than to have an independent association as an intermediary between the injured workman and his doctor. This removes one man from the chain who has been extracting his profit, and is certainly the most sensible way for the medical profession to handle such situations.

By far the largest per cent of contracts for medical service in Washington and Oregon are made by organization in the lumber industry. There is a small amount of coal mining in Washington, but it amounts to only a fraction of the total. However, in the rest of the western states, many of the central states, and part of the eastern states, mining becomes a very important item. The various plans in force vary considerably throughout the country. A few of the mining companies own their own hospitals,

and offer complete medical care for a fixed periodic deduction from wages. Of course all these workers are protected by workmen's compensation legislation so that the employer is theoretically responsible for care for conditions arising as the result of employment. That this does not always work out according to the original intention seems to be the case in a few instances. This is particularly so in the southern West Virginia soft coal fields. In this area, it has been the custom to make a special deduction from wages to cover the cost of care for non-compensable illness. This is provided entirely through contracts with outside hospitals and so forth as none of the coal companies own their own hospitals. These are the same hospitals that care for workmen who are injured at work and who are supposed to be cared for at the company expense. It seems to be true, however, that in practice, the employees contribution for non-industrial care has been stretched to cover the costs of industrial care as well and the companies have been paying little, if anything. This has been possible due to certain ambiguities in the wording of the original act. Efforts are still being made to rectify this situation.

Altogether there were in 1930 some 670,000 gainfully employed persons in the lumbering, mining, and fishing industries who were receiving some form of medical care through fixed periodic payments, and about 571,000 employees of steam railroads who were similarly fortunate. Evidence of similar plans in other industries are almost negligible.

A thing which few people seem to remember is the very

vigorous campaign for compulsory health insurance which was carried on in this country from 1914 to 1920. It came through the efforts of social scientists and professional social workers united in the American Association for Labor Legislation. In 1907, at the first convention of this body, Professor Henry R. Seager gave an address outlining a program of social legislation with special reference to wage earners. He stressed the importance of medical care and monetary relief for illness not directly traceable to employment and expressed the opinion that voluntary health insurance would be a more congenial solution to Americans than a compulsory system. In 1908, the Russell Sage Foundation sent Dr. Lee Frankel and Mr. Miles Dawson to Europe to study and report upon existing systems of health insurance. In 1911, Louis D. Brandeis addressed the National Council for Social Work on "Workingman's Insurance: The Road to Social Efficiency". On the program of every social work or medical convention, the problem was represented. The Progressive Party at its Chicago convention in 1912 adopted as its plank for social legislation the report on this question just accepted at the Conference of Charities and Corrections. In December, 1912, the American Association of Labor Legislation appointed a committee on social insurance. Among those on the committee were Dr. D. M. Rubinow, Henry Seager, Dr. Alexander Lambert, and Dr. S. S. Goldwater.

The program of the American Association for Labor Legislation consisted of two definite phases. The first extending from 1912 to late in 1915 consisted of educational preparation, to use

a more modern term "propaganda". The second phase started in November 1915 with the publication of a Standard Bill for introduction in various state legislatures.

The various features of the bill show an amalgamation of principles of both German and English systems.

1. The bill was intended to insure all persons earning $1,200 a year or less who were covered by the workmen's compensation laws.

2. The costs of administration and benefit were to be paid one-fifth by the state, two-fifths by the employer, and two-fifths by the employees. This was true for those workers making $12.00 a week or more. For those making less, a declining scale of payments was proposed so that workers making $5.00 a week or less contributed nothing while the employer paid everything not paid by the state. The amount of the contributions was to be calculated so as to cover the cost of the prescribed benefits.

3. The cash benefit was to begin with the fourth day of illness and to continue for a maximum of twenty-six weeks in a year. The cash benefit was to be scaled as were the payments. Wages above $7.50 paid two-thirds of the wage. Between $5.00 to $7.50, the benefit was $5.00. Below $5.00, the benefit equalled the wage.

4. Medical benefit was to be complete domicilary and office care. If hospital treatment was needed, it was to be substituted for all other benefits except payment of one-third of the weekly wage to dependents for a period up to twenty-six weeks.

5. A maternity benefit was available to insured women and wives of insured men. It was to consist of medical, surgical, and obstetrical aid and the payment of the regular sickness benefit for eight weeks.

6. A funeral benefit of $50.00 was included.

7. Additional benefits were at the option of the insurance carrier.

8. Insurance was to be carried by "Insurance Funds" under state supervision. Medical disputes were to be settled by a medical board.

The U. S. Public Health Service was in favor of compulsory health insurance and felt that state public health departments were best suited to manage the plan. The National Convention of State Insurance Commissioners appointed a committee which reported favorably in 1916. And in 1916, a resolution (H. J. Res. 159) to create a Federal Commission to prepare a plan for national insurance against sickness, invalidity, and unemployment was introduced in the House of Representatives. The resolution was pigeonholed, re-introduced at the next session, referred to a committee and was never heard from again. The outbreak of the World War prevented the culmination of the plan to hold an International Conference on Social Insurance in Washington in 1915.

During this period, five states considered the Standard Bill in their legislatures, some of them several times. Thus New York's legislature considered it in 1916, 1917, 1918, 1919; and 1920. Massachusetts in 1918; New Jersey in 1918; Ohio in 1919;

Pennsylvania in 1917.

All of these states and some others appointed commissions to investigate the question of health insurance.

The California Commission was one of the first. It concluded that health insurance would offer a powerful remedy for the conditions of the wage earning class. They broadly outlined a plan, pointed out some specific faults in the "Standard Bill", and pointed out that an amendment to the state constitution was necessary before the legislature could pass social insurance legislation. A second commission drew up a bill, but the proposed amendment was turned down by the voters in October, 1918 by a two to one margin.

The Ohio Commission recommended compulsory health insurance as a means of distributing the costs of sickness and of providing adequate medical care adequately compensated. Recommendations with regard to child welfare and so forth were promptly enacted by the legislature, but the health insurance question was "tabled".

The Illinois report published in 1919 represented the most exhaustive study of the problem and contained a great deal original research. They figured that the total cost of sickness, including wage loss, amounted to about $75.00 per family per year, or about 5.8 per cent of income from all sources. This amounted to about $85,000,000 yearly for the state of Illinois. The majority of the commission felt the insurance principle should be applied but favored volition rather than compulsion. The minority

report strongly held for the compulsory form.

The Massachusetts Commission reported in 1917. Four of the nine members felt that some form of health insurance would be desirable, and it was recommended that a second commission be appointed to consider only the health angle instead of social insurance in general. This second commission reported in 1918 and was of the opinion that health insurance was neither needed or wanted by the workers in the state.

The New Jersey Commission was appointed in 1911 with the specific problem of studying old age insurance. Finally in 1918, they reported that sickness was a more pressing problem than old age and recommended passage of health insurance legislation immediately. They stressed the effect of the increasing number of women being employed and its effect upon mounting morbidity rates. Nothing further has been done.

The Wisconsin Commission came back with a Chamber of Commerce like report extolling the thrift and hardihood of pioneer stock and so forth. The majority were of the opinion that the cost of health insurance was excessive and that there was no need for it anyway. A one man minority report disagreed most strongly.

The Connecticut Commission of 1919 definitely recommended against health insurance legislation but suggested that the state might do more to improve living conditions and prevent sickness.

During the time from 1916 to 1919, the New York State Reconstruction Commission carried on an active investigation of health insurance, and in 1919, came out as definitely in favor of

compulsory health insurance for the state of New York. The New York Legislature was the principal battle ground of the whole campaign, and here the opposing forces put forth their greatest efforts. On April 10, the Senate passed Senator Davenport's bill under an emergency message from Governor Alfred E. Smith urging its passage. However, after a sharp skirmish in the Assembly, the bill was defeated. It was again brought up in 1920 but never got "out of committee".

The opposition forces were composed of four groups: the employers, the commerical insurance companies, organized labor, and the medical profession.

Employers branded it as a form of class legislation which unjustly taxes various classes for the benefit of one.

Insurance companies were against it because they were specifically excluded as carriers. This was the result of much study of existing systems and was intended to eliminate many of the abuses and faults that were seen to result from dual coverage and excessive commercialization. Unfortunately it aligned against the bill a very large and powerful lobby which was in no small part responsible for defeating it.

Organized labor, particulary Samuel Gompers, had always been strongly opposed to what might be termed a paternalistic policy on the part of management. They felt that any such move should come as a result of labor union activity.

The medical profession was afraid it would lose its shirt, and so it climbed on the band wagon. This comes at a time

before the English system had had time to iron out its difficulties, and the medical journals in this country were full of cases of their English brethren. They were told how 27,000 English doctors had signed a statement that they would refuse to give service unless their demands were met, and how 10,000 doctors had sent in their resignations. This is especially interesting today in view of the fact that the British Medical Association has for several years past heartily indorsed National Insurance and has asked that it be extended in scope to include dependents and to provide specialist as well as general practitioner service.

SOME RECENT DEVELOPMENTS IN AMERICA

There has been a good deal of venom and vituperation in the arguments pro and con on the subject of compulsory health insurance, socialized medicine, state medicine, etc. The A. M. A. has, with considerable justification, maintained that there are a multitude of experiments going on at the present time trying to find the answer to this problem of distrubuting medical care. Many of these experiments have been instigated by members of the medical profession, some are community projects, many are frankly money making propositions. It will be of great value to examine some of these in trying to come to some conclusion on the basic question involved. It will be physically impossible to even enumerate all the particular plans and projects because they total over one thousand; so it will be necessary to pick a few typical examples of various types and let them speak for the ones not mentioned.

Probably the best way to classify these various plans is according to the classification of the Committee on the Cost of Medical Care. The divisions they used are as follows:

1. Plans under professional sponsorship.
2. Plans under consumer sponsorship.
3. Plans under community sponsorship with professional participation.
4. Plans under joint professional and consumer sponsorship.
5. Plans under commercial sponsorship.

Plans under professional sponsorship are of two types: those of county and state medical societies aiming to care largely for indigents and very low wage groups, and private group clinics which are largely for the more prosperous income group.

Two of the county plans will be discussed as indicative of the possibilities in this form. The Alameda County plan in Oakland is directed mainly at the lower income groups who can pay something for their care. Prior to 1932, the near indigent class received care through a number of uncoordinated part pay clinics along with the totally indigent who received the same service free. In 1932, the care of the indigent was transferred to the County Institutions Commission and the clinics were closed. To take care of the near indigent, members of the county medical society voluntarily entered their names upon a rotating register as being willing to accept a limited number of these patients on a part pay basis. The doctor at the head of the list is called, and he makes one call whether there is any pay or not. He makes individual arrangements as to fee, and is not obligated to return if no pay is forthcoming. After he has taken a case, his name is put at the bottom of the list, and he is not called again until all the other doctors have had a case too. In 1933, a total of 2,077 cases were referred to physicians under this plan. A questionaire sent to the physicians involved was answered by 70 per cent covering 1,304 cases. Of these cases, 74.3 per cent were actually seen while 25.7 per cent were not seen. Of the 969 patients actually seen, 76 per cent paid at least some fee while 24 per cent paid

nothing. The total paid by the 736 patients was a little over $5,000, or about $7.00 per patient.

The Wayne County Medical Society, Detroit, plan has received a great deal of publicity especially in medical journals which laud it as a workable plan not upon an insurance basis. The poorer classes are divided into three groups: the unemployed on relief are cared for at the expense of the FERA, the unemployed not on relief are cared for through the Medical Relief Committee of the Wayne County Medical Society, while the unemployed persons earning small wages or salaries (an interesting classification apparently peculiar to the Bureau of Medical Economics of the A. M. A.) are served by the new Service Bureau of the Wayne County Medical Society. Practically speaking this is a collection bureau, retaining 10 per cent of collections, to which doctors refer patients unable to meet regular fees. The principal item it seems to offer is application of the installment plan to paying medical bills, and the material I have found does not make clear whether or how much charges are scaled down for individual financial inadequacies. One of the most important features of the plan is the cooperation between the medical profession and large blocks of industrial workers. The latter have been enrolled in the scheme at the instigation of management, and perhaps have thus an increased conciousness of what the doctor has to offer them. In my mind, the principal value of such a scheme is the possibility that it may lead to a medical service of real value. It has been quite a common occurrence that schemes of this type starting from the

financial and have found themselves gradually forced into the medical service field on a group insurance basis usually through the pressure of the demands of the industrial groups enrolled. At the moment, it is very much a question how much the medical situation of the Detroit workers has been improved by this plan, but it may be a step to a more comprehensive plan.

Group practice is an entirely different affair which is aimed in an entirely different direction than the county plans just outlined. It is projected largely as a new form, improved or not as one sees fit to interpret it, of medical practice largely replacing the individual general practitioner and the free lance specialist. Its form is very simple, a group of doctors representing the various specialities who associate themselves in partnership or as a corporation. Arguments for this form center around the pooling of space, equipment, and personnel with a resulting saving to both doctor and patient. The arguments against it are the old stock about loss of doctor patient relationship, commercialization and so forth. The question of the place or future of group practice is not one which can be settled by sighting a few examples of existing groups. The answer to the question is one of personal interpretation based largely on individual background. It is very much the same as one's politics or one's religion, either you believe in it or you don't.

There is no question that private practice suffers when group practice becomes established, but that in itself is not a valid argument against group practice if the service is superior.

The criticisms of unfair competition and unethical practice may be justified in some cases, but the same evils appear at times in individual practice and are not in any way peculiar to the group system. The one thing that can be pointed to and not be successfully evaded is the abolition of the old family doctor relationship to the patient. This "old saw" has been worked overtime, and the "Old Doc" himself would probably be amazed and flattered to find out what a prince he has become. There is no reason at all why the "personal touch" need be lost in a properly administered group, and the idea has been presented that this sympathetic doctor patient relationship may be far more important to the doctor than it is to the patient, a possessive rather than altruistic impulse.

The Committee on the Cost of Medical Care published a detailed study of fifty-five group clinics and estimated that there were about one hundred more active at that time (1931). There were about two thousand practitioners engaged in this type of practice, mostly in groups of ten or fewer members. The majority of these groups are to be found in the middle and far west.

There are two types of physicians working in these groups: the owners and the employees. The former own the physical plant and share in the profits while the latter are usually on a salary, frequently with a bonus provision. In the groups studied, there were one and three-tenths employed physicians to every one owner physician. In the average instance each owner had between $13,000 and $14,000 invested in physical equipment, supplies and so forth.

The average clinic gross income per member was $15,000, the average net being $9,750. Thus the shrinkage from gross to net is about 33 per cent compared to the 50 per cent usually accepted for private practice.

The advantages of group practice to the doctor are many. Expenses are reduced, laboratory and consultation services enhanced, administrative worries are shifted to a business manager, there is increased opportunity for vacation and graduate study, and private research is facilitated.

On the other side of the ledger is mainly the throttling of the old G. P. and the loss of the sympathetic doctor patient relationship. In reality there is no reason why group practice should descend to machine methods, and there has been a very real move on the part of group practitioners to maintain the "personal" relationship.

The second class of medical service experiments are those organized under consumer sponsorship. First under this heading might come the medical care provided under the workmen's compensation laws. Enough has been said of this already so that a general idea of how it works is apparent. Secondly we might consider plans proposed and sponsored by the management of industry. As an example of this, we will discuss the Medical Service of the Endicott-Johnson Corporation, one of the world's largest shoe manufacturing establishments. The Medical Service was instituted to provide medical care under the workmen's compensation law. At employee request, this service has been gradually extended until 97 per

cent of the 45,000 workers and workers' dependents are supplied complete home, office and hospital care at a yearly expense to the company of about $900.000. This service is supplied by twenty-three full time physicians, numerous consultants from neighboring areas, and a complete staff of technicians, visiting nurses and so forth. The quality of the service offered is judged to be as good as standard in similar communities in all respects and far above average in the practice of preventive medicine and obstetrics.

Third under the classification would come plans prepared and carried out by employees. These take the form of employee mutual benefit associations, of which there are several hundred in this country. The usual benefit association gives only a small cash benefit, but occasionally one like the Stanacala Employees' Medical and Hospital Association of Baton Rouge, Louisiana offers real medical service. In this instance, the association hires a surgeon, an eye, ear, nose and throat specialist, and five general practitioners, as well as two nurses who are laboratory technicians. Complete medical, surgical and hospital treatment is available to workers and their dependents at a cost of $3.00 a month.

As a fourth sub-class would be plans jointly controlled by management and labor. An example of this would be the medical service available in Roanoke Rapids, North Carolina. Five physicians and two nurses are hired by four local textile mills and the power company. The local hospital is supported by a $.25 check off

per week from the workers. In return they and their dependents are entitled to complete home, office, and hospital care.

This whole plan has undergone a severe shake up as a result of the prolonged business depression and attendant curtailment of industrial activity and unemployment. Originally the local industries built the local hospital and deeded it to the municipality as an eleemosynary institution. An employee contribution of $.25 per week was applied to current hospital expenses, and the doctors were paid by the industries at a rate of $.25 per employee per week. In addition, the local industries made up an annual hospital deficit of about $10,000. The only other source of hospital income was from the Duke Foundation which gave $1.00 for each free patient day.

As a result of decreased employment and a corresponding decrease in contributors, the ante has been raised to $.50 per week, one half going to the hospital and one half going to the doctors. There has been a great increase in the number of free hospital days and a greater contribution from the Duke Foundation, but this contribution does not equal the added expense which came right back to the lap of local industry. This is one of the most difficult problems in the whole social insurance field which keeps bobbing up on every side. Things run fairly smoothly during good times, but during a period of widespread unemployment, demand for care increases while contributions decrease, throwing the load right back into the lap of charity, in short, the whole idea of the plan is defeated. The answer to this problem has not been

found, and it may be true, as the American Medical Association constantly reiterates, that the solution is largely an economic one aimed at "flattening out" the business cycle.

The advantages of industrial medical service such as outlined in the last few pages may be summarized:

1. The form of financing makes a larger total amount of medical service available to a given group than that group would ever enjoy under a private practice system, and still the cost is not excessive to any one individual.

2. Both doctors and patients realize some of the same benefits of organization and service previously outlined under group practice.

3. The patient is encouraged to visit his doctor earlier in his illness.

4. Physicians incomes are larger and more stable than among private practitioners practicing in a similar economic group.

The disadvantages may also be summarized.

1. Since management of these plans is in the hands of laymen, professional standards may be compromised.

2. The doctor loses much of his independence.

3. There may be exploitation of the doctor.

4. Receipt of medical care is usually dependent upon continued employment, lapsing with loss of job.

The next main class for discussion contains those plans which are community sponsored with professional aid and participation. Advances have been along many fronts. Among them are

improved middle rate hospital service as in the Baker Memorial Unit at the Massachusetts General Hospital, another is the development of pay clinics such as that at Cornell University in New York, another is in the extension of public health nursing and service of trained nurse-midwives, another very important one is expansion of government health services, occasional tax supported rural physicians as in Saskatchewan, and increasing scope of university medical services.

The Baker Memorial plan is merely an agreement of the hospital staff to provide service at minimum rates, all bills to be collected by the hospital. All possible economics in administration are made which do not compromise the service given. Whenever possible a flat rate covering all expenses is agreed upon before the service is rendered.

One of the principal extensions of government agencies in medical problems has been the activity of the Farm Security Administration. Working on the premise that a healthy individual is a better mortgage risk than a sick one, they have advanced to those on their roles one dollar a month for medical care. The areas in which this agency operates are North and South Dakota, Arkansas, and Alabama principally. In North and South Dakota alone, they have on their roles between 70,000 and 80,000 families. In many areas, the doctor's principal income is that he receives through the FSA loans. The relief dollar is apportioned 51 per cent to the doctor, 39 per cent to the hospital, 6 per cent to the dentist, 3 per cent to the druggist, and 1 per cent to the

nurse. Whether this is a valuable development or not is open to question. Unquestionably in some areas it is the only thing that has enabled the doctor to stay on the job. On the other hand, there is much dissatisfaction among both doctors and patients. Of course, the government can not go on lending these people money for ever. It is much like the WPA, admittedly only a temporary measure, but how are you ever going to stop it.

The tax supported rural physician is a modern development in Saskatchewan. Here the situation was much like the one confronting doctors in rural Dakota, there just wasn't enough in private practice to keep the doctor going. In order to keep the doctors from walking off and leaving them, various communities subsidized their doctors from tax funds. In the original instance, the community gauranteed its doctor $1,500 for one year. The recently adopted maximum income is $5,500. An average of the whole area shows the capitation fee to be about $1,90 per year. For this the doctor gives general practitioner service including obstetrical work, minor surgery, public health inspection, immunization and so forth. Major surgery is definitely not included. The main advantage of the plan is that medical service is supplied in an area which would otherwise be without it, quite a major advantage. The disadvantages are many. The main one being that the doctor is more or less at the mercy of the community employing him. If that community is well run, he will have a fairly good set up, but on the other hand if they are disposed to exploit their doctor, he is completely powerless to do anything other than move out, and

there seems always to be another ready to fill the vacancy.

Another example of a community medical service project is that sponsored by the Thomas Thompson Trust Fund in Brattleboro, Vermont. This plan was started in 1926 to provide nursing service, and in 1927, a medical service plan was started as well. The Association for Nursing Service supplies home and hospital special nursing at one third the regular cost and practical nurses at one half the regular cost. The maximum benefit so available is $200.00 The annual cost of this service is $2.00 for single persons, $3.00 for married couples, and $.50 apiece for children under sixteen. The Association for Hospital Service is aimed to take care of only major procedures; so all charges up to $30.00 are paid entirely by the patient. Above $30.00 the association will pay all bills including the surgeons up to a maximum of $300.00. Annual dues for this service are $5.00 for single persons, $7.50 for married couples, and $1.00 apiece for children under sixteen. Operating expenses for both associations are borne by the Thompson Trust. Under these arrangements, the Association for Nursing Benefit has operated for four years at a total profit of $652.91. The Association for Hospital Service has operated for a similar period at a deficit of $1,115.38. One thousand dollars of this has been taken care of by a gift from the Thompson Trust.

The New Bedford Medical Insurance plan is very similar to the one just outlined, in fact, it was patterned after it. It was organized in 1929 on an experimental basis to run for two years. At the end of that period it was decided to continue the

service indefinitely.

There are a multitude of hospital service plans including the Baylor University plan in Dallas, the Grinnell, Iowa plan, and a local plan of quite recent origin. These are all plans to cover the cost of hospitalization more or less completely in return for a monthly payment of from $.50 to $1.00. They vary in completeness, some including x-ray, laboratory, and nursing service, and some do not. They are all alike in that they do not pay the doctor. In this respect, they are quite incomplete, and in general their clientele will be found to consist of a group considerably above that which needs the most help. They are a step in the right direction, but in the minds of the most radical, a very inadequate one in the solution of the whole problem.

The fourth great group of experiments is a minor variation of ones already discussed. These are plans under the joint sponsorship of professional and consumer groups. In effect this comprises private group clinics who contract with large groups of workers either through management or labor organizations to supply complete medical service for a fixed payment per member of the group to be cared for. This is a type of practice which is a very common adjunct of group clinic practice. Perhaps one of the largest groups engaged in this praticular type of work is the Ross-Loos Clinic in Los Angeles. They first started in this work when they were approached by the management of a local utilities company with a group of about a thousand employees. This was in 1929. By 1932, the clinic was composed of over twenty

physicians and had over 9,000 patients on a contract basis. The care given consists of complete medical care for contributors and dependents at a cost of $2.00 per month.

The fifth, and last, classification is of experiments or plans under commercial sponsorship. There are several types, some of which can be disposed of very quickly. One of these is the application of installment payments through loan companies. Some of this is through outfits buying up physicians' accounts, but small loans from banks, loan associations, and finance companies comprise most of the business. This is not a medical problem and does little to remedy the situation. The load is not decreased or reapportioned, only deferred, and in the process, the load is increased by interest payments.

Commercial health insurance companies seldom provide more than cash benefits. The expense of such insurance makes it unavailable to those most needing it, and it seems significant that many of the largest and most reputable life insurance companies have stopped issuing health insurance.

On the other hand, there are some medical benefit corporations offering medical service. As an example of this, we may consider the Columbia Casualty Company, a subsidiary of the Ocean Accident and Guarantee Corporation of London. This company, with offices at 1 Park Avenue, New York, has started operations principally in California. The plan is simple. For a payment of from $3.00 to $10.00 a month complete medical care for self and dependents is guaranteed. Of the premiums, 45 per cent

are allocated for payment of medical service, 12.5 per cent for hospitalization, and 42.5 per cent for promotion, organization, sales, administration, and profits. This service is aimed at incomes of from $2,000 to $10,000 yearly. The medical profession is generally hostile to such organizations, but they always seem to find some one willing to provide the necessary services. It must be the ones not asked who do the howling, and they probably have a legitimate howl because private practice is difficult in the face of such competition. Of course, the one great fallacy in the scheme, from the medical view-point, is that some one other than the doctor is reaping profit from supplying medical care. This merely means that the doctor is missing the boat. The application of such a scheme depends also upon the action of various state laws, because it is not uncommon to find state laws specifically denying corporations the privilege of practicing medicine.

This very answer has but recently (September 2, 1938) been affirmed by the Supreme Court of the State of California in the case of the People of the State of California versus Pacific Health Corporation. The defendant corporation offered to its subscribers complete medical care, the cost to be defrayed upon the insurance principle. This was held by the lower courts to be a violation of the California Medical Practice Act (Sections 2000-2049 of the Business and Professions Code). This act holds that a Corporation may not engage in the practice of professions such as law, medicine, or dentistry. This precedent has been established in numerous cases recently as: People versus Merchants' Protective

Corporation, 189 Cal. 531; Painless Parker versus Board of Dental Examiners, 216 Cal. 285; etc. The defendant in this action did not challenge this doctrine but sought to establish the idea that its activities were not the same as those held to be illegal. It was argued that the defendant did not perform medical services, but merely furnished competent physicians who performed such services as they felt necessary in the way they felt the instance justified, and that these physicians were compensated only for services rendered and not in contemplation of any future service. In short, defendant held the doctors to be independent contractors, and that such a theory absolved the corporation of the charge of practicing medicine.

The court failed to agree with the distinction drawn by the defendant, and the judgment of the lower court was affirmed, and the corporation enjoined from continuing its illegal practices. As to the contention of the defendant that an affirmation of the decision of the Superior Court would outlaw the medical activities of all religious, fraternal, charitable, and employee organizations existing in the state, the court held that there was a fundamental distinction between corporations organized for profit and those on an eleemosynary basis and that the two were not to be considered upon the same footing. The majority opinion closed with a discussion of social insurance and held that there was not a sufficient weight of public opinion behind proposed changes to justify the courts reversing established opinion upon the grounds of public policy. Such action would be appropriate only upon the part

of the legislature.

The minority, three out of seven justices, felt that the cases sighted for one reason or another did not apply and agreed with the contention of the defendant that it was not engaged in the practice of medicine. They felt that the court was placing a stumbling block in the way of progress when acting in the guise of public policy, and that the part of the legislature was to protect the medical practitioner from this type of competition if they felt it to be unfair.

In a similar manner, the majority of states have proceeded against corporations engaged in the practice of medicine for profit.

The decision of the California Supreme Court in Health Service Board of the City and County of San Francisco versus Harold J. Boyd, as Controller of the City and County of San Francisco, and Duncan Matheson, as Treasurer of the City and County of San Francisco is of much interest. The Health Service Board is a body set up under the Health Service System which was established by charter amendment in 1937. The plan is to establish a health service system for city and county employees in return for monthy deduction from wages. The plan was first submitted to a referendum vote of employees involved who approved by a vote of 7428 to 939. The charter amendment was then submitted to the electorate who approved, and became effective by concurrent resolution of the legislature on April 14, 1937.

The plan is to extend to all city and county employees complete medical and hospital care at a monthly cost of $2.50. Those whose religion dictates otherwise, those who make more than $4,500 a year, and those who have already made provision for adequate care may withdraw if they so desire, all others participate. Any doctor or any hospital accepting the regulations of the Board may be chosen by the patient.

The majority of the court could not find that the charter amendment was unconstitutional and sighted numerous instances in which various pension systems, sanitary codes, and so forth had been upheld under the municipal home rule doctorine. They directed the Controller and Treasurer to release to the Health Service Board the funds they had collected but had refused to turn over to the Board pursuant to the provisions of the charter amendment.

Subsequent events in the State of California have become increasingly interesting and significant. In the election last fall, certain candidates, notably Governor Olsen, made repeated reference to the necessity for certain forms of compulsory social legislation. The introduction of Assembly Bill 2172 and Senate Bill 1128 known as the Social Insurance Act on January 25th did not come as a surprise, in fact, they were anticipated and even superseded by the proposal of the California Medical Association on January 14th to organize a non-profit corporation to be known as the California Physicians' Service which will offer to the state voluntary health insurance. I have not been able to obtain sufficient data to compare the two proposed plans as to

adequacy, cost, administration and so forth. All that can be said is that both have been carefully prepared and probably represent a compendium of the best features of existing voluntary and compulsory plans. Both are too new, still in the formative stage, to be of more than speculative value, but week by week developments in California will be of the very greatest interest to all medical men in this country. The medical men of California have inaugurated their plan with the definite idea of forestalling the state compulsory plan, a very commendable move on their part and a good example for other state medical societies. Of course California is noted for "advanced" legislation and a similar crisis may not necessarily be pending in all other states, but it would certainly behove all state medical societies to inform themselves on such matters so that they may be prepared to direct rather than to be directed.

It must not be thought that all the action in this controversy is centered in California. Washington, D. C. has been the site of one of the most acrimonious altercations in the entire country. This has centered around the activities of Group Health Association, Inc. The Group Health Association is a corporation organized within the Home Owners' Loan Corporation for the purpose of providing medical care to employees of the HOLC in return for a small periodic payment. Care was to be extended to the whole family and to include complete medical, hospital, and specialist service. The details of the actual operation of the scheme have been completely submerged in the welter of litigation and debate over

the legality of the fundamental scheme and the appropriateness of the hostile step taken by various branches of organized medicine.

As early as 1936, the future activities of the HOLC in the field of health insurance were mentioned in the annual report of the Twentieth Century Fund. On February 24, 1937, the new corporation, Group Health Association, filed its certificate of incorporation. By November 1, 1937, the new group started Supplying medical service to about one thousand employees and their families. At the present time, there are about twenty-seven hundred subscribers who with their families represent about ten thousand individuals.

Almost from its very inception the organization has been in hot water. In November, 1937, counsel for the District of Columbia Medical Society presented a brief to the United States District Attorney purporting to show that Group Health Association was a corporation illegally engaged in the practice of medicine. Resultant publicity lead to a Congressional investigation of the appropriation of $40,000 of HOLC funds to the support of Group Health Association. The investigating committee came to the conclusion that the shift of funds was made in a manner without legal foundation in administrative practice.

The next item in the American Medical Association's chronological record of the case is a press release by Attorney General Cummings to the affect that anti-trust proceedings were to be launched against the American Medical Association and af-

filiated individuals for coercive actions in restraint of the free practice of medicine. In the meantime, the United States District Attorney and the Superintendent of Insurance for the District of Columbia were preparing to prosecute Group Health Association on the grounds that it was illegally engaged in practicing medicine and the insurance business. To forestall these prosecutions, Group Health petitioned the District Court for a declaratory judgment in which the court might express its opinion on the legality of the actions of Group Health Association. The court, through Justice Jennings Bailey, rendered a memorandum opinion on July 27, 1938 to the effect that activities of the Association did not constitute the practice of medicine, and, that since benefits were medical and not monetary, their activities could not be construed as being insurance. This is an interesting contrast to the decision sited of the California Supreme Court in Pacific Health Corporation versus the People of the State of California. Latest information indicates that the Superintendent of Insurance is perfecting an appeal while the United States District Attorney has apparently let the matter drop.

During the Fall of this last year, both sides, the Department of Justice on one hand and the American Medical Association on the other, were busily engaged in smearing each other as liberally as possible. The whole thing seems to boil down to this: the activities of organized medicine were unquestionably extended to the utmost to hinder the continued operation of Group Health Asso-

ciation in every possible way; on the other hand, the American Medical Association holds that such activity is justified in that the corporation is acting illegally and in a manner which they consider to be to the detriment of both the public and the medical profession.

The means employed by the medical society to force its will were quite simple, physicians employed by the Group Health Association were removed from the rolls of the county medical society and thus lost most of their hospital privileges. One hardy individual who persisted in spite of threats and warnings found his malpractice insurance canceled at the instigation of the medical society. Being made of quite stern stuff, he re-insured himself with Lloyds of London, but at a rate twice that he had been paying before. There have been numerous cases refused hospital admission because of their connection with Group Health, one case requiring an emergency operation had to have a regular surgeon do the work because the Group Health surgeon was not allowed in any hospital. In this case, the cost was much greater than necessary because it would ordinarily have been covered by the Group Health plan and also the free choice of physician for which the American Medical Association fights so fiercily, was set aside completely.

The action of the Department of Justice is quite without precedent and has brought much condemnation from the press. One's personal reaction will probably be dictated by his ideas on the fundamental question rather than the application of the

legal principle involved. It seems to me, however, that there is no reason why, if the medical profession is acting in a manner detrimental to public policy, they should be exempt from prosecution just because of their professional position or because of any great service they may have rendered.

On October 17th, the Grand Jury was impaneled to hear evidence upon this case. Evidence was heard until December 20th at which time the Grand Jury returned a true bill against the American Medical Association, three local medical societies, and twenty-one individuals charging them singly and collectively with actions which were restraining the free practice of medicine. This was again the signal for a strom of abuse directed at the Department of Justice on the part of the press. Smart opinion seems to indicate that the Department of Justice is not anxious to continue prosecution under the indictments because they are none too sure of conviction, and for fear that the example of the "martyred" doctors might instigate a wave of reactionary legislation. In their original moves, the Department indicated that the proceeding was to be in equity rather than on a criminal basis. This was similar to their action against the motion picture industry, the purpose being that proceedings may be dropped if the offending party, admitting its wrong, will make redress, that is, will institute positive reforms to alleviate the ills complained of. What it actually is is a sort of big stick to force some one to do what you think is right. If you agree with the reforms demanded, the method seems quite affective, but if you happen to

be on the other side of the fence, the whole method is diabolical in the extreme.

At the moment things are in a state of deadlock. The Department of Justice does not want to move unless it has to, and the medical profession, feeling it has the upper hand, prefers to wait the game out. What will happen is difficult to say.

The National Government has become interested in the problems of medical care, and its probable course of action is of great interest and importance to anyone interested in the future of medical practice. After the passage of the Social Security Act in 1935, the President appointed an Interdepartmental Committee to coordinate the health and welfare activities provided for by that Act. A sub-committee, the Technical Committee on Medical Care, was appointed to study particularly the questions of adequacy and availability of medical care. The report of this sub-committee was published at the National Health Conference held in Washington July 18 - 20, 1938.

The findings of the Technical Committee fall into four main classes:

1. Preventive health services for the country as a whole are grossly inadequate.

2. Hospital and institutional facilities are inadequate in many areas, particularly rural areas. Financial support for hospital care and for professional services while in the hospital are both insufficient and precarious, especially in the case of those who can not pay for what they need.

3. One third of the population is receiving inadequate or no medical service.

4. An even larger proportion of the population is suffering from economic burdens created by illness.

The recommendations of the committee were specifically directed at these deficiencies.

1. Expansion of public health and maternal and child health services at a maximum annual expense of $200,000,000 for the former and $165,000,000 for the latter.

2. Expansion of hospital facilities at an average yearly cost for ten years of $146,050,000.

3. Gradual expansion of care for the medically needy at an initial expenditure of $50,000,000 to be increased to $400,000,000 by the end of a ten year period.

4. Insurance against loss of earning power must be provided for, but not necessarily as a part of the medical program. Perhaps in a manner similar to unemployment compensation or old age insurance.

Eliminating duplication, this calls for an annual expenditure of about $850,000,000 for a period of ten years to bring facilities up to requirements and thereafter an annual budget of $705,000,000 to keep them going.

The idea of the Interdepartmental Committee is to formulate the various proposals into bills for the consideration of Congress. The idea of the American Medical Association is to further compound the number of investigations of medical care,

which they so frequently ridicule, in the hope of producing one which will be at variance with all of the many conducted heretofore.

So far the only bill actually proposed setting forth any of these recommendations is Senator Wagner's series of amendments to the Social Security Bill. These call for a gradually increasing federal expenditure reaching a maximum of $80,000,000 in ten years. The channels in which it is to go are patterned almost exactly after the recommendations of the Technical Committee on Medical Care. The method of disbursement is to be through state and local governments on a matching basis such as that used in PWA grants.

In order to fulfill the purpose for which this paper has been written, the last section should consist of a summary and conclusions. The whole paper in itself is but the briefest summary of some facts and many conclusions. For my own part, I find it extremely difficult to come to a definite conclusion. In my mind, there is not the slightest doubt that there are gross inadequacies in our present system of supply and distribution of medical services, and this belief will not in any way be shaken by the findings of the current investigation of the American Medical Association which has all the earmarks of a "white-washing" as far as I am concerned. Perhaps this is being overly dogmatic, but even with the American Medical Association denying the charge as vociferously as possible, the majority opinion of persons who have thought about the problem for more than ten minutes at a stretch is overwhelmingly of the view that gross inadequacies

exist. The question of what to do about it is the great problem. Plans for voluntary health insurance are hopeful; so is the rapidly increasing popularity of hospitalization insurance, and the extension of public health activity against social disease. But in my own mind, when I think of the vast number of the unemployed and the innumerable reminders of the indifference of such individuals to their social responsibilities, I can not escape the conclusion that there are a great mass of people who must be taken care of in spite of themselves. Perhaps this view is overly pessimistic. I sincerely hope it is. Let us first try every possible means of solving this problem upon a rational voluntary basis. Like almost everyone else, I have grown up with the idea that anything run by the government is bound to be run badly. There are innumerable local and national examples of this, and yet there are in existence instances of government run organizations of highest efficiency, even in this country. The crux of this situation lies in the fact that the civil service has not yet reached into the high places. This was pointed out by Sir Henry Brackenbury in a speech in Los Angeles within the last year. This is not the time or place to launch a discussion of the civil service, but the value of a permanent high quality personnel in high administrative office would be almost a prerequisite for a workable plan of state health insurance. For lack of such civil service, Sir Henry expressed the opinion that a national health insurance plan would not prove to be a workable scheme in this country.

In closing, I would like to present a short discussion

of a much different attack upon the problem of the patient and the doctor. It has been customary through our entire experience, and through that of our ancestors, for the patient to seek the doctor only after disease had set in. In reality he may have been sick for a long time, but in his position as the primary diagnostician, he may have been mislead by a feeling of well being or at least a lack of disease. This leads one immediately to the conclusion that the individual has no right to be the primary diagnostician because he is manifestly not capable of doing the job properly. Next might be asked, does the doctor in the periodic health examination so important to our conception of preventive medicine do an acceptable job as the primary diagnostician? The answer, after due consideration, is bound to be no. In the first place, he only sees the patient once or at best twice a year, and in the meantime, almost anything might develop. Also, and equally important, he is not well enough acquainted with with his patient to interpret what he finds. Exactly the same findings in two different individuals may mean in one case that the individual is the same as he always has been and as he always will be, that he is well; while in another case, they may be a marked change from what he was a month ago and may be the incipient signs of serious sickness. If this reasoning is followed out, the inevitable conclusion is that for adequate primary diagnosis, the doctor must observe the patient continuously in his normal surroundings.

Having followed through exactly this train of reasoning, a group in Peckham, England decided upon an experiment, known as

the Pioneer Health Centre. This is a project supported by private funds the whole aim of which seems to be to find something positive about health and to improve the recognition of sickness without actual objective or subjective disease.

To this end a family social and recreational centre has been established to serve the residents of a definite area. Membership is restricted to families as a whole, not to individuals. The centre is staffed by four doctors with ample technical assitance and the use of complete laboratory facilities. The service is diagnostic not therapeutic, the members all being insured under the National Insurance Act and thus have the services of a panel doctor. The service consists of a complete overhaul on admission, special premarital consultation, pre and post natal examinations, consultation upon request at any time, and continuous social observation.

The best possible review of the work done lies in the summary published in Biologists in Search of Material, the interim report of the Pioneer Health Centre covering the first eighteen months experience from 1935-1937.

Their summary derived from the consideration of subjective facts follows.

1. The efficiency of the medical service depends primarily upon diagnosis.

2. The primary diagnostician is the sufferer.

3. Therefore the primary diagnosis depends upon the subjective state of the disease.

4. The sufferer, however, is guided to seek treatment, not by the subjective state of disease, but by the conciousness of social incapacity.

5. There may be a wide lapse between the suffer's diagnosis of the disease and his diagnosis of social incapacity.

6. The professional diagnostician is concerned with the objective facts, that is, the disorders which underlie the disease of the sufferer.

7. A toothache may produce more disease than the most dangerous cancer. There is no necessary parallel between the degree of disease and the nature and severity of any underlying disorder.

8. The sufferer is too often content to have the disease alone alleviated, even when a cure is available for the underlying disorders.

9. Disorders do not always cause disease, they may remain marked by a sense of well being.

10. Well being, like disease, can be associated with any form of disorder.

11. Well being, like disease, has varying degrees. The most exhuberant sense of well being may be associated with the most serious disorder.

12. Well being completely discounts for the individual the importance of any manifest disorder.

13. Well being deceives not only the individual but the casual observer, however well trained in diagnosis.

14. It is not, as in disease, the unwillingness of the sufferer to seek treatment which keeps the disorders underlying well being from the medical services, but well being itself.

15. Therefore well being must be studied if we are to find a way out of this impasse.

16. Hence the recognition of well being as a cloak covering every kind of disorder is of primary importance.

17. As it would be hopelessly impracticable to apply every available test to exclude every known disorder, a test must be found for the detection of well being.

18. This can only be done through a study of well being itself, not of the disorders that underly it.

19. This implies a comparative study of well being and health.

20. Our hypothesis to be tested is that the sense of well being is the consequence of the effectiveness of the process of compensation in the body.

21. The effectiveness of compensation may be costing the body dear because it is being maintained at the expense of extravagant wear and tear of the compensating organs.

22. Compensation is brought about by the adoptive function of the organism turned into a defensive measure and is carried on at the expense of the reserves of action and function. It is a spending or a wasting process.

23. The adaptive function of the organism is in health directed to the digestion and synthesis of material and the con-

ditions of the environment. Health is thus a process, not a state. It is a cummulative as opposed to a spending process, not defensive but acceptive.

24. On this hypothesis it may be possible to direct experiment and observation toward a comparative study of the physical process of health and well being respectively.

25. This research work demands suitable material so the major problem still remains: how to collect and retain families suitable for observation and research?

Perhaps all our efforts at providing medical care are aimed at the wrong target. Is medicine seeking to look the barn of the body after the horse of health has been stolen?

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