CHAPTER IV

PLANS AND EXPERIMENTS NOW UNDER WAY

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Both practitioners and laymen have long been aware of some of the deficiencies in medical practice set forth in Chapter I. Aside from the traditional methods of medical practice with which all are more or less familiar, a variety of suggested solutions have been tried in various parts of the world. The Committee and cooperating agencies have gathered data on the most significant of these plans and experiments in the United States. Four of them have been sponsored by professional groups and four by consumer groups. The largest number, thirteen, have developed under community groups, some voluntary and some governmental, but with the participation of professional groups. One is sponsored jointly by professional and consumer groups and three by commercial agencies. In addition, the Committee has been provided with the findings of two recent studies of European health insurance organizations. In the succeeding pages, this material is briefly summarized.

A. UNDER PROFESSIONAL SPONSORSHIP

1. Care of Indigents by County Medical Society.—In the last few years at least ten county medical societies in Iowa, and a few in other states, have contracted with their local governments to provide medical care to the indigent, *i. e.*, persons officially understood to be recipients of charity, in return for annual payments by the local governments. In Marion County, Iowa, for example, the society was paid $2,430 for such service in 1932. Care is usually provided by the physicians in their own offices, each one caring for those patients who come to him. The funds are customarily used to pay the physicians' dues to local, state, and national medical associations, and the residue, if any, is pro-rated to the physicians on the basis of their work. In most instances there is no central direction of the work and no systematic division of labor, although in a few counties an organized clinic has been established.[1] †

* Free use has been made in this chapter of material from the Summary Volume (Publication 27), Parts VI and VII. The reader interested in more detailed information is referred to this volume and to the various studies therein summarized.

† The reader will find all the reference notes to this chapter assembled at the end thereof with numbers corresponding to those in the text.

The advantages of this experiment are that it places definite responsibility on the county medical society to care for the indigent, and on the local authorities to pay the physicians, at least in part, for their services. Control over the quality of the service and the division of the compensation is left in the hands of the organized profession.

On the other hand, the service usually is not well-integrated; some practitioners may render more than their fair share of service; and dentistry, nursing, and hospitalization either are not provided at all, or are not closely related to the physicians' work. Moreover, preventive work is not extensive. This development, so far as the Committee knows, has appeared, with one exception, only in small rural communities. The compensation to the physicians, which ranges from $2.60 to $10 per patient per year, is usually inadequate.

2. Provision by County Medical Societies of Insurance for High-Cost Illnesses.—A type of insurance for high-cost illness was proposed during the summer and autumn of 1932 by a committee of the Medical Society of Milwaukee County, Wisconsin. It suggested the formation of "The Community Medical Service of Milwaukee," under a joint medical and lay executive board, to enroll individuals and groups of persons who would pay regular monthly dues (based on incomes) in return for designated professional services. These services would be provided by any member of the county medical society who wished to participate in the plan. Subscribers would be allowed "free choice" among the participating physicians and institutions.

It is expected that "indigents" would make no payments of monthly dues, but would receive services from the tax-supported county hospital and dispensary. Sums might be paid from taxes to the Community Service for the work of physicians in the homes of indigent patients. A non-indigent subscriber "when sick, must purchase direct from his doctor, in the usual manner of private practice, his entire medical care up to a certain amount (in any one year) before he is entitled to medical service under this plan." Arrangements could be made for deferred payment for such services. "The amount of medical care to be purchased direct is to be determined in proportion to income."

The net result of the financial arrangements would be to protect the subscriber and his family against the burden of catastrophic illnesses only. Simple illnesses would continue to be paid for on a private fee basis, unless a succession of such cases in a family brought the total expense beyond the specified limit. Preventive services, except those required after the limit has been reached, would not be financed through the regular monthly dues. No provision is made for coordinated work and its probable economies.

3. Joint Use of Professional Personnel and Equipment.—In many cities, groups of 3 to 20 physicians or dentists have reduced their overhead costs through joint utilization of office space, waiting rooms, scientific equipment, and technical and clerical personnel. Instead of referring X-ray procedures and laboratory tests to other practitioners, for example, some such groups pool the expenses of maintaining X-ray and laboratory personnel primarily for their own patients. Some groups jointly employ a lay business manager. Customarily the participants in such a plan maintain separate financial relations with patients and complete professional independence. Often the groups are composed exclusively of specialists. Thus certain economies are effected and physical proximity facilitates consultation and saves the time of patients. Such arrangements do not, however, aid the patient who needs a general practitioner, nor provide a sure method of directing patients to the right physician. Furthermore, there is no effective professional control over the quality of service, nor any assurance that economies will be shared with patients. Such arrangements may be considered as temporary phases of the transition from individual practice to private group practice.

4. Private Group Clinics.—The idea of group practice in medicine has developed rapidly in the United States, particularly since the World War. The distinguishing features of a private group clinic are: (1) its physicians are engaged in the cooperative practice of medicine and use many facilities in common; (2) all or most of the physicians are engaged full-time in clinic work; (3) two or more of the major specialties are represented on the clinic's staff, and an attempt is made to give complete service to all patients who are accepted; (4) the patients, although frequently under the charge of a single physician, are the responsibility of the whole group; (5) the

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financial responsibility rests with an employed business manager; (6) the income is "pooled" and the remuneration of practitioners is determined by agreement among the practi-

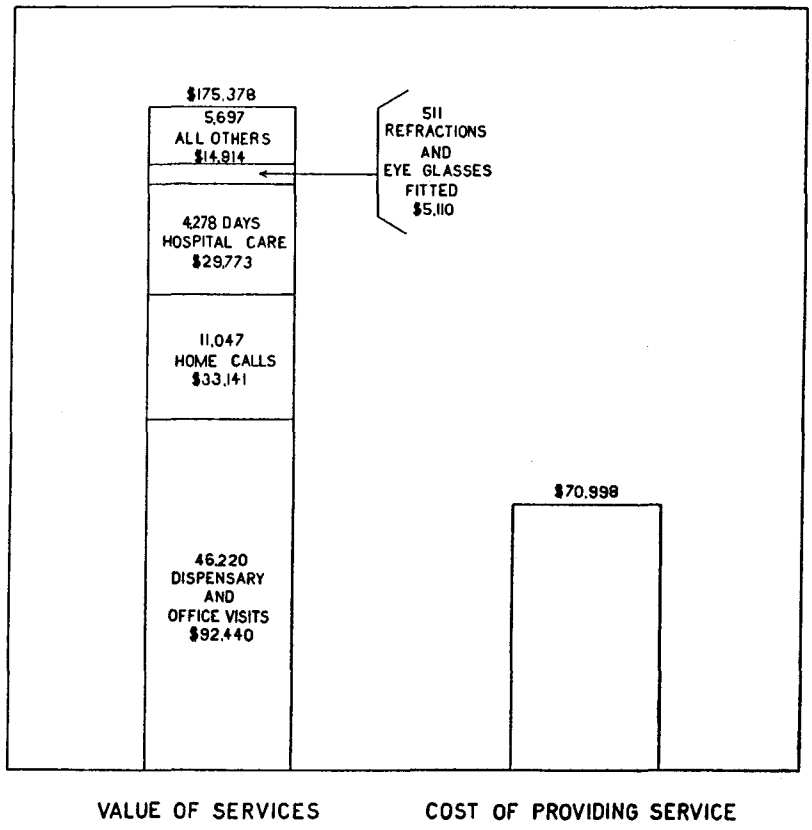

FIG. 13. THE ECONOMY OF ORGANIZATION

This diagram shows that, while the medical service furnished by the Homestake Mining Company in 1930 to 1,855 employees and their families cost approximately $70,998, when the services were appraised at prevailing local fees (for instance, when 46,220 dispensary and office visits were figured at $2.00 per visit), the total value of the services provided was over $175,000. The value of hospital care includes the estimated cost of professional services to 88 medical and 348 surgical cases in the hospital.

tioners, rather than according to the services rendered.[2] There are now about 200 such clinics in the United States.

A variation of the private group clinic is the diagnostic clinic, sometimes conducted by physicians as a self-supporting enterprise, and at other times conducted with semi-charitable

intent. In the diagnostic clinic a group of specialists join to diagnose obscure cases. Such clinics usually accept only patients who are referred by physicians, and send the patients back to the referring physicians for treatment. Frequently a flat fee of $50, $75, or $100 is charged for a complete diagnostic examination and report. Such clinics are feasible only in large metropolitan areas where there is a substantial stream of patients; and they have rarely been successful except when associated with the staff organization and therapeutic services of a hospital or general clinic.

There are two-fold advantages to group clinic practice: advantages to the patient and advantages to the practitioner. Briefly the advantages to the patient are that he may receive a better quality of care from a well-rounded group, than he would from individual physicians, practicing independently and without intimate and continuous contact with each other. This is a special advantage to the patient with an obscure illness or one difficult to treat. The clinic as a whole assumes responsibility for the quality of the patient's care, and he finds it convenient to obtain the services of all needed specialists in one place and as part of one arrangement. From the physician's point of view, clinic organization has the advantages that his time is conserved, the spread between gross and net income is diminished, a large amount of equipment is usually available, consultation with colleagues is facilitated, vacations and opportunities for postgraduate study are more readily provided, net income tends to be higher and stabilized, records are more nearly complete, and research is facilitated through the existence of a larger number of records.

A comparison of the financial aspects of group practice with individual practice presents certain problems. A special study of a number of typical private group clinics showed that among the expenses of the clinics are included many costs not usually incurred by individual practitioners, for example, laboratory and X-ray services which private practitioners usually obtain by sending patients to hospital or commercial laboratories. The average "overhead" of individual private practitioners is approximately 40 per cent of their gross income, while, for the group clinics studied, the figure was only 33 per cent. When, however, the items are considered in detail and an

endeavor made to eliminate those expenses which do not usually appear in the individual practitioner's account, the "overhead" of the clinics is reduced to about 25 per cent and, in some instances, to only 20 per cent.

The disadvantages of group practice are: there is a tendency to reduce the personal relation with patients, although many clinics guard against this, and there may be a lack of privacy for patients and a division of responsibility for their care. The physicians on salary, furthermore, do not have the same personal and professional independence that they have in private practice. Group clinics may be in direct economic competition with private practitioners, and it is sometimes alleged that this competition is "unfair." The economies of group practice in some instances are not passed on to patients, even in part. Some clinics have been dissolved because the physicians could not agree on the division of income.

It is evident that group clinics are feasible only in communities which can support several physicians.*

B. UNDER CONSUMER SPONSORSHIP

5. Medical Service Under Workmen's Compensation.—Forty-four states have workmen's compensation laws, most of which require the employer to provide money compensation and medical services to such of his employees as are injured while working for him. The employer may insure his liability through a commercial company, may self-insure, or may insure in a compulsory or optional state fund. Medical service is frequently paid for according to a fixed fee-schedule which aims to set rates comparable to those usually charged

* In the Committee's study of the organized medical service at Roanoke Rapids (Publication No. 20) it was concluded that 5,000 persons may be sufficient to support an organized medical service but that 10,000 or more are preferable. The organized medical service at Roanoke Rapids, although it serves about 10,000 persons, is not sufficiently complete to be taken as an example of the "community medical center" described in Chapter III. Of the six physicians who participate in this organization, one is chief of staff, two perform major surgery and render general medical service, one is a pediatrician and general practitioner, one is a general practitioner, and one is an eye, ear, nose, and throat specialist. Thus there is no radiologist, no pathologist, no obstetrician or gynecologist, no dermatologist, no urologist, and no psychiatrist. Some of these deficiencies could be remedied if slightly more money were available. Others are inherent in medical practice in small isolated communities and must be overcome by association with larger institutions. In the Committee's plan presented in Chapter III, organizations the size of the Roanoke Rapids service would be "affiliated branches" of community medical centers. The medical service at Ft. Benning, described in Publication No. 21, illustrates very effectively the type of organization which the Committee visualizes for community medical centers.

for such services to persons in similar economic circumstances. The payment is made by the employer, the insurance company, or the state fund, as the case may be. Service under workmen's compensation legislation, even though inadequate in some instances, has undoubtedly been of great benefit to injured workmen and has been satisfactory to physicians in some states as, for example, in Ohio where there is a state insurance fund and where the fee schedule was approved in advance by the state medical society. In some other states, there has been constant bargaining between the physicians, interested in receiving adequate payment for their services, and the insurance companies, interested in keeping down the costs of service. In a few states, the agencies which provide medical service for compensation cases also provide service for non-compensable illnesses, the employee, with or without the aid of the employer, meeting the cost of this service through wage deductions. In many states a maximum liability is specified, which is often insufficient to meet even hospital costs without professional fees.

6. Medical Service Furnished by Employers.—Industrial medical service was formerly considered synonymous with low-grade care, since industries which employed "company-doctors" were frequently more eager to get cheap service than to get good service. Often the lowest bidder was given the contract, regardless of his qualifications, and little or no equipment was provided.

There has been in recent years a substantial growth in both the quality and the amount of medical service provided by industries or by groups of employees. Most of such service is diagnostic and preventive, patients being referred to their family physicians for treatment, and is usually limited to employees and furnished without charge. In April 1930, probably at least 1,000,000 employees in the railroad, mining, and lumbering industries and a large number of their dependents were receiving medical service furnished by the employer or under industrial auspices.[3]

Some industrial medical service is comprehensive and of good quality. The Endicott-Johnson Corporation, for example, provides its employees with the services of general practitioners and specialists, hospitalization, dentistry, nursing, and

laboratory and X-ray service. The service compares favorably with general practice in small cities, and in preventive medicine and obstetrics is better than that ordinarily received by working class families in such cities. In 1928 this service cost the company $21.81 per individual to whom it was potentially available.[4]

7. Medical Service Provided by Employee Groups.—There are several hundred employees' mutual benefit associations which provide various kinds of cash and other benefits to their members.[5] Most of these associations provide only cash benefits during sickness, but a few of them provide medical service. One of these, the Stanacola Employees' Medical and Hospital Association of Baton Rouge, Louisiana, employs a surgeon, an eye, ear, nose, and throat specialist, and five general practitioners, as well as two nurses who are laboratory technicians. Complete medical, hospital, and nursing service is furnished to the members and their dependents at a cost of $3.00 per employee per month.[6]

8. Medical Service Provided Jointly by Employers and Employees.—Frequently industrial medical service is supported by both employers and employees. In Roanoke Rapids, North Carolina, five industrial establishments have cooperated with their employees in the development of a community medical service.[7] Unlimited hospital care; home and hospital nursing; and home, office, and hospital attention by physicians are included. The employees pay 25 cents per week, which amounts to nearly $33,000 per year, and the mills pay a total of $56,000 per year. While the funds so provided are not sufficient to prevent certain inadequacies in the service, the medical and surgical care is, on the whole, of a high order.

Discussion of Industrial Medical Service.—The advantages of industrial medical service, whether furnished by the employer, the employee, or both, are in general similar, namely: (1) the form of organization makes possible a method of financing which provides more medical care than most persons in similar economic groups are able to afford under private practice; (2) both patients and physicians realize some or all of the benefits of group organization, as outlined above under "Group Clinics"; (3) although no patient pays excessively for his medical service, a total sum is made available which is sub-

stantially larger than the amount which persons in these income groups customarily pay; (4) the economic inhibition against seeking service early is removed; and (5) physicians' incomes are larger than in private practice among people of the same general economic group in communities of similar size, and physicians can obtain more leisure for study.

The disadvantages of this type of practice are: (1) since the management and direction of the service are almost entirely in the hands of laymen, it is possible for proper professional standards to be disregarded; (2) the practitioners

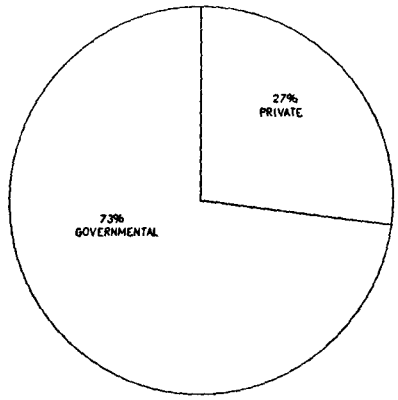

FIG. 14. HOSPITAL SERVICE PROVIDED BY GOVERNMENTAL AND BY VOLUNTARY INSTITUTIONS

This graph (based upon the patient days of hospital service in 1931) shows that approximately 75 per cent of hospital care in the United States is provided by the Federal, state, and local governments. Mental hospitals provide a large part of this service.

lose some of their personal and professional independence; (3) such a system may unfairly exploit the services of physicians; (4) the receipt of medical service often is dependent upon continued employment; and (5) in some areas, notably West Virginia, this plan appears to have been exploited jointly by the employers and the physicians or the hospitals through the provision of an inadequate service of indifferent quality. In some instances, moreover, employers have illegally used the industrial medical service as a device for unloading upon their employees the cost of workmen's compensation.*

* For example in West Virginia, according to a 1931 report by a committee of the legislature, wage deductions for medical service are sometimes used by an employer to pay the cost of

Industrial medical services are feasible, only when there are fairly large groups of employees under one management, or where a satisfactory arrangement can be made for combining smaller groups. A disadvantage frequently found, although not inherent in the plan of organization, is that dependents are not included. Finally, such a system may make the medical service of a community even more dependent upon the stability of industry than it would be under the usual private practice arrangement. The opposite, however, seems to have been the case, during the current depression, in the Roanoke Rapids service.

Industrial medical service is ultimately limited to those persons and their dependents who are employed in establishments with a considerable number of workers. Of the 211,000 manufacturing establishments in the United States in 1929, only 29,000 employed over 50 wage-earners as a yearly average, although their total employees numbered 7,000,000 of the 9,000,000 in all manufacturing establishments. If employees of other types of organizations of suitable size be added, the 7,000,000 might be increased to 10,000,000 or 12,000,000 employees, with 20,000,000 to 30,000,000 dependents, giving a total of 30,000,000 to 40,000,000 persons who might conceivably be served by industrial medical services.

C. UNDER COMMUNITY SPONSORSHIP WITH PROFESSIONAL PARTICIPATION

9. Middle-Rate Hospital Services.—A number of voluntary hospitals in this country are now developing special plans for the so-called "patient of moderate means." [8] The most significant feature of these, as illustrated, for example, by the Baker Memorial unit of the Massachusetts General Hospital, is an agreement between the medical staff and the hospital on a fixed maximum schedule of charges for professional as well as for hospital services, and the adjustment and collection of these charges by the hospital administration, acting on its

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hospitalization for his employees suffering from industrial accidents as well as, and in some cases to the exclusion of, employees suffering from non-compensable cases.

See Pierce Williams, "The Purchase of Medical Care Through Fixed Periodic Payment," (National Bureau of Economic Research, New York, 1932) p. 189-190.

own behalf, and as the agent of its medical staff. An effort to reduce the cost of special nursing is usually an additional feature.

Other hospitals now have flat-rate charges for maternity cases, for tonsil and adenoid cases, and for laboratory service. Some provide for payment of hospital bills in weekly or monthly installments. Several diagnostic clinics, some of which are in hospitals, have flat-rate charges for a complete diagnostic examination. Hospital work under most of these plans is largely if not wholly self-supporting. When deficits occur, they are usually met by public contributions.

Such arrangements enable the patient, *when he becomes sick,* to estimate how much he must spend, and frequently enable him to have the kind of service which he wishes without too great expense. The physicians are also benefited since they can collect something from patients who might otherwise be forced to go without care, or who might use ward services and pay the physicians nothing.

On the other hand, such measures are inadequate. They are largely limited to persons in the middle economic groups. They do not make it easier for people to budget their medical expenditures in advance of illness; they do not encourage either patients or physicians to use preventive measures; and they enable only a small proportion of the lower income groups to pay for satisfactory medical care. Since they provide only for a special economic group, they are feasible only where that group is large, *i. e.,* in cities and large towns.

10. Pay Clinics.—Out-patient departments of hospitals and clinics independent of hospitals were originally only for the very poor. Increasingly they have come to serve persons who are not indigent, but who cannot meet the usual expense of private medical care. A large number of clinics, particularly in the Eastern cities, have begun, since the war, to charge fees for service, usually of nominal amounts, but, in an increasing number of clinics, of amounts nearly or quite sufficient to cover the actual expenses. In many of these clinics, the physicians are nevertheless expected to give their services without charge.

Pay clinics, however, are those in which the physicians are compensated for their services on a salary or fee basis, and

the patient pays the full cost of the service, except, as in hospitals, the capital charges. Some pay clinics, like the Cornell Clinic in New York City, provide general services; others are limited to special fields.

Dental clinics of various kinds are developing in all parts of the country and perhaps an appreciable number of them are conducted on the "pay clinic" principle.[9] Hospitals direct more dental clinics than any other single agency.

Pay clinics furnish good care to persons of small means at a much lower cost, due to the economies of organization and the limitations on the returns to practitioners, than the cost of equivalent service in private practice; but they compete with some local medical practitioners and, unless well organized may provide hurried and impersonal service.

11. Private Office Practice in Hospitals.—In the past, hospitals have been typically used for the care of both paying and non-paying bed patients, and non-paying ambulatory patients. Paying patients who are ambulatory or "office" cases usually have not been received in hospital buildings. Recently, however, the medical staffs of many hospitals have arranged to utilize the hospitals for their private office practice by referring cases for X-ray or laboratory service, by using rooms for consultations or conference with other hospital staff members on private cases, or by actual rental of office space in a hospital building. Data accumulated by the Council on Medical Education and Hospitals indicate that in 1931 nearly 1,000 hospitals were used to some degree by 4,500 physicians who maintained offices or office hours for private ambulatory patients in the institutions.

These procedures have increased the individual practitioner's opportunities to serve cases requiring specialists or diagnostic equipment; they may conserve the physician's time in the treatment of his private cases, and the patient's time also in some instances. From the hospital's point of view, this use of the institution's facilities has had the advantage of increasing the amount of service rendered by the equipment and apparatus, and thus lowering the unit-costs of certain hospital functions and increasing revenue.

The tendency to concentrate private office practice in hospitals faces certain possible difficulties. First, it may give rise

to competition with previously established commercial agencies providing X-ray or laboratory service. Second, some institutions may extend privileges on an uneven or undesirable basis among members of the medical staff or the local profession. Third, the hospital may be embarrassed by demands that office facilities be provided to all members of the staff.

12. Public Health Nursing.—One of the most significant tendencies of the past quarter-century has been the development of public health nursing, under both official and non-official auspices. The visiting nurse, originally employed to care for the sick in the home, has broadened her scope to include health teaching as a major objective; so that public health nursing is now defined as an organized community service rendered by graduate nurses to the individual, the family and the community. This service includes the interpretation of medical, sanitary, and social procedures for the correction of defects, prevention of disease, and promotion of health as well as domiciliary nursing care.

There are two major groups of public health nurses now in service, those employed by official agencies, who commonly devote their time to purely educational work, and those employed by voluntary agencies who also render bedside care for the sick. There is a tendency, however, to consolidate all types of public health nursing in a given community so that a single nurse may render complete generalized service to a given population unit (preferably of not more than 2,000 persons).

Public health nursing provides, mainly to low-income families: health supervision service, maternity service, and bedside care and other services to the sick in their homes. School nursing service in the school and in the home and industrial nursing service both in the plant and in the home include some or all of the above services. Non-governmental nursing nearly always have a medical advisory board to assist in defining the work which the nurses may do. The nurses are expected to cooperate with the industrial or family physician. Financial support comes from tax funds, from public contributions, from payments by life-insurance companies for services to their policyholders, and from fees which are charged only to patients who are able to pay. Public health nursing is available theoretically to all groups of the population, regardless of economic status,

both on a visit and part-time basis, although as yet the middle and upper economic groups use it infrequently.[10]

The outstanding advantages of public health nursing are that it makes a limited amount of nursing service available to many families who cannot afford to employ full-time nurses or who need only occasional nursing, and it offers an excellent opportunity for health instruction of families by example as well as by precept. Every public health nurse is expected to teach her families as much as she can about nutrition, personal hygiene, and social and mental adjustments.

The significance of this movement is that well-organized community agencies, with high professional standards, supply all needs for preventive and curative nursing care in a population group on terms which make the service potentially available for all economic levels.

13. Organized Service by Trained Nurse-Midwives.—About 15 per cent of the childbirths in this county are attended by midwives. In 1925, approximately 300,000 births were cared for by such practitioners, most of whom are untrained, dirty, and superstitious. In contrast to them are a few trained nurse-midwives who handle normal obstetrical cases very effectively. These women are far superior in general education and obstetrical training to the average untrained midwife of the Southern states. The best known example of the use of trained nurse-midwives in this country is the Frontier Nursing Service of Kentucky, whose nurses delivered 818 patients during the six years ending May 1, 1931, with only one maternal death.[11] This organization offers also the customary public health nursing services, a modicum of hospitalization, and from time to time special services of physicians and dentists. The total cost of this service, even though it is carried on in a very remote mountainous region, is only $10.92 per year per person actually served. Because of the poverty of the patients, however, over 95 per cent of even this modest sum must be collected outside the community.

The advantage of this plan is that it brings skilled nursing and midwifery service, on an economical and efficient basis, to families which could not possibly pay the not unreasonable fees of the nearest physician. The same advantage would be realized, although perhaps to a less degree, in the use of

trained nurse-midwives for any low-income group or any group in sparsely settled areas.

The disadvantages of using nurse-midwives are that they are not competent to handle unusual or difficult deliveries, and that, if used in areas where there are physicians, they would care for some patients who otherwise would have the services of a physician.

14. Trained Nursing Attendants.—In Boston, Detroit, and Brattleboro, Vermont, women have been trained as "nursing attendants," to do simple home nursing under the direction of trained public health nurses and, in addition, to perform necessary house work. Charges for such service are somewhat lower than those customarily made by trained nurses.*

Such a service is particularly useful when the homemaker is too ill to carry on her ordinary duties, but not ill enough to require the continuous care of a graduate nurse. It is desirable only when the work of the attendants can be carefully supervised. Eventually it may be provided by a variety of organizations which are in a position to exercise the necessary supervision and control.

15. Expansion of Governmental Health Services.†—Local and state governments have long provided treatment for infectious diseases, especially for tuberculosis, for mental diseases and, more recently, for venereal diseases. In some instances they are beginning to offer treatment of cancer and orthopedic cases. In addition, it has been proposed that the local or state government take up the whole problem of the care of chronic patients.

All these diseases or conditions are very costly to the patient, either because of the nature of the treatment or the long duration of the illness. It is advantageous, therefore, that he be given good care at an early stage in order to avoid, if possible, the disastrous physical and financial effects of a long-continued illness. In many instances he must have some sort of assistance if he is to obtain proper care. From the stand-

* Publication No. 17. At the present time unemployment is so extensive among graduate nurses that many of them are working or would willingly work for rates below those customarily received by trained attendants.

† *Dissenting Statement By Committee Member.*—I believe that governmental care of patients is to be condemned except in the case of illnesses which may involve danger to public health and safety, *e. g.*, tuberculosis, venereal diseases, mental diseases.—J. Shelton Horsley.

point of the private practitioner, it may be desirable to have an organized governmental medical service provide care to these chronic cases, since then the practitioner need not continue treating them long after they have ceased paying him.

The chief disadvantage of such an expansion is the one common to all governmental activities, namely the danger that such services may be subjected to purely political interference, or stifled by a poorly organized civil service. In addition there is the disadvantage—not to be lightly dismissed—that the medical care of families, and perhaps of individuals, may thus be divided among several persons or agencies.

In addition to the development of services for special types of disease, there have been significant growths in two of the accepted public health services, namely, public health nursing and school health service. Public health nursing has been discussed on p. 86-87 above.

Since the first law which provided for medical inspection of school children was passed by Connecticut in 1899, there has been a rapid and substantial growth in school health service in both elementary and high schools. Most of the work for school children is preventive and diagnostic: medical inspection by school physicians, dentists, nurses, and teachers; examination of children returning to school after illness; examination of children about to enter school; and instruction in diet and hygiene. In some school systems, however, certain therapeutic services are also provided, such as the removal of diseased tonsils or adenoids, the filling of dental cavities, the provision of eye-glasses, and the treatment of mental maladjustments.

16. Government Provision of Hospitalization.—Cities and counties have for a long time provided hospitals for the care of the indigent. In recent years some local governments have experimented with the plan of providing hospitalization at moderate rates to *all* classes of the population. Both Cincinnati and Buffalo have large general hospitals open, under certain restrictions, to all residents. Many cities and counties pay non-governmental hospitals on a per capita per diem basis for the hospital care of the poor. Often such payments do not equal the cost of service.

The advantage of governmental aid in the provision of hospital service is that it enables hospitals to render service at lower charges and thereby assists patients in meeting the costs of hospitalized illnesses, which include about 50 per cent of the total costs of all medical service. In some areas, tax funds must be used if hospital service of any kind is to be provided. If state, city, or county aid is given to non-governmental hospitals, the governmental agency can set minimum standards for hospital administration and practice.

On the other hand, since hospital service is only one aspect of medical care, this plan does not solve the problem of providing satisfactory medical service to all who need it. Furthermore many persons hesitate to approve governmental provision or support of hospitalization, because they believe that governmental effort, more frequently than comparable private effort is associated with waste, extravagance, and incompetence. This belief, however, at present rests far more on impressions than it does on adequate factual proof.

17. Tax-Supported Physicians in Rural Areas.—In 30 or more rural "municipalities" * of Saskatchewan [12] one or more physicians have been employed to provide medical service. About two-thirds of the physicians are on a whole-time basis. These physicians are usually also appointed local health officers. The cost of their services, paid through tax funds, is about $7.50 to $10 per family per year.

This system, which was started about 1921, provides physicians with incomes and favorable working conditions and assures their services to many communities which otherwise would not have resident physicians. The costs are so distributed that no individual patients or families are heavily burdened. Early consultation is encouraged, yet there is little tendency among patients to take up the doctor's time for trifling ailments. Preventive measures are utilized freely. Some of the doctors say that their relations with patients are more cordial than when a fee was charged for each service, and, they are saved much financial worry and clerical detail. No community in Saskatchewan which has adopted the "municipal doctor" plan has abandoned it.

* A "municipality" corresponds in most respects to a county in the United States.

The principal disadvantage of the plan is that it is limited to general practitioner's services. It usually does not include hospitalization, nursing, dentistry, and the services of specialists, but, under the usual conditions in other rural areas, these services are available, if at all, only at high cost. Some municipalities have added one or another of these services. The possible disadvantages of salaried practice have been mentioned earlier.* None of these disadvantages has seriously hampered the work in Saskatchewan.

18. State Aid for Local Medical Service.—Several states have found that adequate local public health service probably will not be provided without state financial assistance. One state, New York, has authorized the state department of health to reimburse any county to the extent of one-half its expenditures for the construction, establishment, or maintenance "of a county, community or other public hospital, clinic, or dispensary or similar institution," or "any public enterprise or activity for the improvement of the public health," provided the enterprise is approved by the State Department of Health. In spite of the broad terms of the act, most of the money so far appropriated under it has been for the support of public health activities, and relatively little for direct medical and hospital services.[13]

The advantages of state-aid on a "matched-funds" basis are: (1) it assists rural counties and other counties with relatively low tax incomes to support more nearly adequate medical service than they could otherwise afford; (2) it gives the state a more effective leadership in the development of needed services in rural areas; and (3) it does not deprive the local community of its initiative, responsibility, and control over its own medical services.

Obviously, state aid is not a desirable policy if the officials in charge of its administration are uninformed of or unsympathetic with local needs, or if they attempt to control local activities for political purposes.

19. Insurance for Hospitalized Illnesses.—Several plans have been tried for assisting patients in meeting the costs of the

* See p. 79, 82, of this chapter.

more expensive illnesses. Some of these, such as the hospital insurance offered by the Baylor University Hospital of Dallas, Texas, and by the Community Hospital of Grinnell, Iowa, cover only the cost of hospitalization.[14] Plans of a similar nature are now being adopted or considered in a number of hospitals in the East and Middle West. In these plans, the hospital deals with organized groups of persons who pay a fixed amount per year into a common fund out of which their hospital bills are met. In several instances, a group of hospitals in the same community are endeavoring to work out a joint plan. In Brattleboro, Vermont,[15] and New Bedford, Massachusetts, a somewhat similar type of insurance, covering also part of the cost of professional services, has been offered to individuals instead of to groups. In Great Britain, voluntary insurance for hospital care has recently extended with great rapidity and now covers about six million persons.

The principal advantage of such insurance is that, since it provides financial aid only to those patients who have high-cost illnesses, *i. e.*, illnesses associated with hospital, surgical, or nursing services, its cost is much less than insurance for all forms of medical expenditure. Physicians, nurses, and hospitals gain from such plans since some bills are paid which, in the absence of an insurance plan, would not be paid. Furthermore, practically no financial risk need be involved in the initiation of such plans, and a relatively simple type of organization suffices to administer them.

On the other hand, this type of insurance must provide for physicians' services, hospitalization, dentistry, and nursing if it is to include all the major items which can and do cause "high-cost" illnesses.[16] Since it is usually much more limited in scope, it does not fully solve even the problem of high-cost illnesses. Furthermore, this insurance does not encourage families to provide medical service promptly in case of illness, or fully to utilize preventive services; nor does it take advantage of the economies possible in group work.

20. University Medical Services.—Since student health departments were started as early as 1860, experience with this type of service has been extensive. On January 1, 1931, there were 153 colleges or universities with organized divisional

student health services. Many of these provided a complete medical service at costs of $9.00 to $30.00 per capita per school year. At the University of California, physicians' services, dentistry, hospitalization, laboratory service, physical-therapy, x-ray service, and drugs are furnished to 9,800 students in residence at a cost, including capital charges, of $17.86 per eligible student for the school year.[17] This service has most of the advantages of industrial medical service, and the further advantage that the university, with its tradition of high professional standards, instead of the industry or the employee benefit association, occupies the position of leadership. There are, at present, approximately 1,086,000 college students and 85,000 college and university teachers in the United States. If such service were extended to all students, all faculties and their families, and all other university employees and their dependents, it would probably reach a maximum of about 1,300,000 persons.

21. Health, Hospital, and Nursing Councils.—There are in the United States at least a dozen health councils, the oldest of which was formed in 1917. The Cleveland Health Council, which may be considered representative, acts as a cooperative agency to coordinate public health work. Through group planning and expert study, it attempts to prevent the placing of undue emphasis on certain health problems at the cost of others, to discover gaps in the community's health program, and to build up services and initiate new programs.[18] Similar activities for hospitals are carried on by a number of hospital councils. In five cities, nursing councils study the nursing needs of the community, promote measures to meet these needs, and help prepare nurses for service.[19]

After more than ten years' trial, it is now clear that when health councils are provided with competent personnel, necessary funds, and able guidance, they can exert needed leadership in public health activities, can coordinate activities that are overlapping and disjointed, and can successfully sponsor the development of new health activities, even though, as is usually the case, they have neither legal nor financial control over the various health agencies.

The principal limitation of health councils as now constituted

lies in the fact that they usually consider only public health problems and do not embrace the equally important fields of medical service to individuals. Adequate and able representation of the medical, dental, and nursing professions in such councils is essential.

D. UNDER JOINT SPONSORSHIP OF PROFESSIONAL AND CONSUMER GROUPS

22. Periodic Payment Plans of Group Clinics.—At least a dozen private group clinics now provide medical service to groups of persons for periodic payments. Usually these plans are worked out at the suggestion of and in cooperation with consumer groups. The Ross-Loos clinic in Los Angeles, for example, at the request of a group of employees, began about three years ago to offer medical service complete except for dentistry and nursing, to several such groups. The number of subscribers has grown steadily, and includes at present about 9,000 persons who pay $2.00 per person per month. In addition, laboratory service and the services of physicians are offered to family dependents without charge, although dependents pay cost prices for hospitalization, drugs, and a few other items.[20] The various employee groups meet with the clinic directors periodically to discuss questions relating to the medical service.

This method of payment has proved popular with patients, and it is being steadily extended in various parts of the country. It has all the advantages of industrial medical service, and in addition the advantage that the control of medical service is in the hands of the practitioners who direct the clinic, while the formation of policies is shared by representatives of the patients.

The most important disadvantage of this service, as at present operated, is that there is an increased opportunity for clinics to engage in competition as to price, which is disastrous to professional standards and therefore to the welfare of patients. In fact, such competition has already appeared in California, Washington, and some other states and, to date, no method of controlling this abuse has been effective. There are,

in addition, the disadvantages of group clinic practice, which were listed above.*

E. UNDER COMMERCIAL SPONSORSHIP

23. Installment Payments Through Loan Companies.—Within the last decade attempts have been made to systematize the paying of medical bills through installment payments. A number of proprietary organizations have been formed to purchase the accounts of practitioners and collect what they can, or to advance money either to the patient or the practitioner and collect from patients. These associations have not yet reached large proportions. But "loan sharks," remedial loan associations, and personal finance departments of established banks also are extensively used to provide funds to meet medical expenses. About 28 per cent of all such loans are for this purpose. The annual interest rates on these loans vary from 12 to 43 per cent or more.[21]

The installment plan, however, does not provide funds which otherwise would not be available. In fact the interest rates increase the total burden. The burden of payment is spread over a period of time, but it is not so distributed that the public helps to lighten it when it threatens to destroy the solvency of the patient.

24. "Health Insurance" Provided by Insurance Companies.—Many commercial companies offer "accident and health" policies which provide limited cash benefits to meet the costs of medical care. None of them provides medical service, except occasionally nursing. These policies are usually

* *Dissenting Statement by Committee Member.*—This paragraph overstates the disadvantages. In a number of towns in the Middle West where this form of medical service is in operation, no such difficulties have appeared. The undoubted evils of competition as to price exist among physicians in private practice and are emphasized where, as in many cities, there is a local over-supply of physicians. Complaints by physicians who feel themselves injured by a competitive process do not necessarily imply that the process is injurious either to the profession as a whole or to the public. Group practice may render certain evils of competition more apparent, but for this very reason they may be more susceptible to control. The above paragraph refers to the situation on the Pacific Coast as if it were full of hopeless evil, whereas it has undoubtedly extended medical service to many persons and stabilized, if not increased, the incomes of a considerable number of physicians. The vigorous efforts now being made by professional bodies in those states to deal with its evils may be expected to bring these in hand within the near future, not, however, by suppressing plans of group payment and group practice, but by adjusting them under proper professional and public control.—Michael M. Davis and Louis I. Dublin.

limited to certain classes of people, and, even when sold on a group basis, are too expensive to be of wide-spread value.

25. Medical Benefit Corporations Operating for Profit.— Particularly in California, a large number of medical benefit corporations, organized by laymen for profit, sell health insurance policies to individuals and provide service through contracts with individual practitioners and hospitals. In some cases, the corporations write group contracts with employees and arrange for the employer to collect the premiums.[22] One such company planned to use 25 per cent of its income to pay physicians and the remaining 75 per cent for selling costs and profits.

This plan has some disadvantages which are unique. In the first place, it is under neither professional nor community control, and the insurance departments of the State of California and other states have refused to exercise jurisdiction over such corporations. As a consequence, many companies have started with inadequate capital and reserves, only to fail. In the second place, the management is entirely lay and relatively unconcerned with professional standards. Much of the medical service has been obtained from the lowest bidder, although sometimes it is paid for at the workmen's compensation rates. Finally, this plan, instead of obtaining the economies and professional advantages of group organization and group practice, actually adds to the cost through expensive selling procedures and payment of profits to owners.

F. EUROPEAN DEVELOPMENTS IN THE PROVISION OF MEDICAL CARE

In Europe, as in the United States, the provision of medical service is mainly in the hands of individual practitioners although hospitals are well developed and, in some localities, clinics and other forms of group practice provide medical care in conjunction with group payment by insurance or taxation.

During the past fifty years, most European countries have made payment for medical care the subject of public action and a large part of the population now pays for medical service through regular periodic payments to a mutual benefit society or health insurance "fund." These funds are non-profit

organizations formed of the employees of a given establishment, of all insured persons in a given locality, or of the members of a fraternal or cooperative society who may be scattered throughout a whole country. Such funds are under some government supervision, but usually are not administered by the government. As a rule the payments made by the wage-earner are supplemented by approximately similar amounts paid by his employer; in some countries a payment is also made from tax funds. These sums together make up a total from which are paid (a) certain expenses of medical service, and (b) a cash benefit in partial re-payment of the loss of wages during illness.

Hospital care in Europe, except in Holland and Great Britain, is predominantly supported by taxation. In the latter country, a great extension in hospitals under government auspices has taken place in recent years. In some countries a few health insurance funds maintain their own hospitals or sanitoria but, in general, hospital care is not part of insurance schemes. Payments from insurance funds may, however, meet part, but usually only a small part, of the cost of care of insured persons in government hospitals. In England, voluntary insurance against hospital care is increasing. Almost everywhere in Europe, the typical general hospital does not receive private paying patients in the American sense. The medical staff of a European hospital is usually composed of a small number of physicians on salary, who do not carry on any private practice. Thus only a small proportion of the medical profession have direct contact with hospital service.

In most countries of Europe, every employed person earning less than a specified income is legally compelled to insure himself against illness, and the insurance fund to which he belongs must in return provide him with certain medical services. Additional services may be furnished if the workers and employers choose to assess themselves larger amounts. In all these countries, voluntary insurance on a cooperative, non-profit basis, preceded the adoption of any legal requirement to insure. In many European countries, insurance is also provided against industrial accidents, invalidity, old age, and other hazards.

The scope of the medical service provided by insurance plans

varies widely. In Italy, only the treatment of tuberculosis is provided; only the services of general practitioners are offered in Great Britain; in most of Germany and Austria a nearly complete medical service is given. Complete medical care in all forms is not provided in any insurance scheme.

The British system requires all employed persons earning less than £250 annually to insure, and furnishes cash benefits together with the services of general medical practitioners and such medicines as they prescribe. Hospitalization, dentistry, the services of specialists, and the medical care of dependents are not included, although dental care has not infrequently been added by voluntary local action. The British Medical Association opposed the insurance scheme at its inception in 1912 but has now officially recognized its benefits and advocated an extension of the scope of service and the inclusion of dependents.

Germany passed its first compulsory health insurance law in 1883. It applied only to certain industries in which voluntary insurance had already developed. Succeeding legislation has greatly extended the system both in the number of persons served and in the range of benefits provided, so that now almost two-thirds of the entire population are covered. Since the War, voluntary insurance has been extending rapidly among persons who are above the economic limit of the compulsory insurance system.

France introduced compulsory health insurance only in 1930, providing medical and cash benefit for persons whose income does not exceed 18,000 francs. Russia under the Soviet régime is the only country in Europe which has undertaken state medicine, with medical services and facilities provided and administered by the government. Denmark, which with Sweden depends on voluntary insurance, has brought the majority of the population under the system. In Denmark the individual is not legally required to insure against illness, but he has many indirect incentives to join and faces certain legal disadvantages if he does not.

The system of furnishing medical service and of remunerating physicians and other practitioners varies greatly. In Great Britain, every physician may undertake insurance practice if he wishes and he is remunerated at a fixed amount per patient

per year. Free choice of physicians among those wishing to accept insurance practice is assured. In Germany and elsewhere on the continent, physicians are usually paid according to an agreed scale of fees worked out between the insurance funds and the physicians. Salaried physicians are employed in some localities and consultation clinics and other special clinics, which employ full-time or part-time physicians, are increasing. Under the recently enacted French law, fees for medical and dental attendance are paid directly to the physicians or dentists by insured persons, according to a fixed scale, but any practitioner may charge beyond this scale if the patient agrees. The patient is reimbursed by the insurance fund up to the amount of the official fee schedule only.

Thus, in general, European countries have focused their attention upon the problem of payment rather than upon methods of providing medical care. Relatively little attention has been given to the relation of insurance practice to preventive work, although there are evidences in England and in some localities upon the continent of increasingly close relations. Care of the indigent is almost everywhere a direct responsibility of government and is often furnished by salaried physicians. Methods of group payment for medical service have been utilized through two generations and in many countries with widely varying social, economic, and political conditions. This experience provides a massive and growing body of detailed information regarding policies and administration. The working relations between the medical profession and the insurance system have reached a high point of cooperation in Great Britain and Scandinavia. In Germany there are wide differences between localities, and some severe local conflicts have occurred.

Only the barest summary is possible within the present limits of space, but some suggestive conclusions may be quoted from two recent and comprehensive studies of medical service in Europe. A. M. Simons and Nathan Sinai conducted in 1931 a study of the professional and economic problems of health insurance for the American Dental Association.[23] Their principal findings were:

1. There is practically no important opposition to the principle of health insurance in any country where it now exists. There is criticism in plenty and constant effort to change details, but no agitation for repeal.

2. The national associations of physicians and dentists have, over and over, formally approved the provision of health care to the lower-income classes through insurance.

3. There is practically unanimous agreement that the insured receive better medical care than they did before they were insured.

4. There is wide variation in professional incomes under insurance; but they will average at least as high and probably somewhat higher than they were in private working-class practice before insurance.

5. Every attempt to apply the principles of voluntary insurance on a large scale has proved to be only a longer or shorter bridge to a compulsory system. Every so-called "voluntary" system is successful in just about the proportion that it contains compulsory features.

6. In every insurance system there has been a fairly steady increase in the number of persons sick and in the number of days of sickness per capita annually. The tendency seems sufficiently well established to justify the conclusion that universal free medical service does not reduce the amount of *recorded* sickness.

7. A comparative study of many insurance systems seems to justify the conclusion that the evils of insurance decrease in proportion to the degree that responsibilities, with accompanying powers and duties, are intrusted to the medical professions.

The conclusions of Sir Arthur Newsholme in *Medicine and the State,* terminating his series of international studies of medical service in Europe, may be summarized as follows:[24]

1. The advance of medicine has made it impossible for doctors individually to meet a large share of the medical needs of the community. Close cooperation between general practitioners and specialists is required. Without it, the efficiency of medical service is reduced by inadequacy and discontinuity.

2. The problem of medical care has ceased to be one which can be solved by direct family payments and it has become one of determining the best method for securing satisfactory medical care when needed by provident measures (insurance) supplemented perhaps by communal aid (taxes).

3. If the family is to continue to be the unit of medical practice then a team of medical practitioners and not an isolated practitioner should be the unit on the medical side.

4. In every national health insurance plan in Europe, financial as well as medical aid is given during illness and in most countries the insurance is obligatory. These two facts of compulsion and the dependence of monetary benefits on medical certification, especially the latter, have given rise to trouble. The separation of medical service and cash benefit has been suggested. But medical certification would continue to be needed. The problem of certification is largely one of morale. Education among the insured will help them to realize the mutual character of insurance. It will probably also be necessary to give the insured a direct personal interest in keeping cash benefits to a minimum.

5. In recent years, public health authorities have provided, not only much hospital treatment, but also certain specialized services. The most important are pathological and other facilities for diagnosis and provisions for medical care of motherhood and childhood.

6. In European experience, the care of parturient women by trained midwives has been associated with a high standard of safety in childbirth.

These twenty-five types of development in the United States and the many developments abroad show a ferment at work in medical practice which contains great possibilities for good and evil. The Committee is aware of the fact that some of the plans are mere attempts to capitalize for private gain the people's need for better medical service. It is equally aware of the dangers inherent in other plans. Each should be viewed as an experiment and subjected to the careful evaluation that is given in a scientific laboratory. Some of them appear to the Committee to be very promising.

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