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Medicine must determine its own future : `Voluntary' or `Compulsory'

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MEDICINE MUST DETERMINE ITS OWN FUTURE 'VOLUNTARY' OR 'COMPULSORY'

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INTRODUCTION

Down through the ages there always has been some group or groups trying to change the methods of distributing medical care to the public. The strength of such reformers waxes and wanes, and over the centuries their influence has been good. They produce the necessary element to keep the medical profession on its toes. Such conflicts between the liberal and conservative schools of thought are a necessary evil.

At the present time the agitators for a revision of medical practice are well organized and are backed by many large sections of our population. Public interest was first stirred by the British Beveridge Report. Under the guidance of the reformers there have been many plans and systems offered.

Up to now all of the planning presented to the public in the United States has been done without approval or aid of the American Medical Association as a unit. Many individual opinions have been voiced, but no basis for cooperative action has been reached. The time has come for the medical men to awaken to the problem. If there are to be changes, the profession itself should plan them. And as we shall see, there are going to be changes.

In order to plan there must be some understanding of the situation and the suggested solutions. The problem might be approached in this manner:

1. An analysis of new ideas of medical practice now functioning.
2. A study of the various proposals for a change.
3. A recognition of the true status of the needs for medical care.

4. An evaluation of the various plans as to practicality, considering the influence of politico-social-economic factors.

5. A sensible honest conclusion from which to plan for the future.

This thesis endeavors to present a fullfillment of those five parts of the approach. The number of books and articles directly quoted is not great. The last three sections of the thesis are an expression of the author's opinions gained from extensive reading of recent literature on all phases of the question.

PART I

A STUDY OF SOME EXISTANT SYSTEMS

FOR COMPREHENSIVE MEDICAL CARE

FOREIGN SYSTEMS: GERMANY

In considering the historical background of the various existant plans for facilitating the care of the public as a unit, one cannot do better than to begin with a review of the German system as it existed before the present world-wide debacle.

In 1833, the great German Premier Bismark inaugurated a program of compulsory health insurance. This was instituted not from a humanitarian point of view, but as a political expediency. Bismark was greatly troubled by the rising power of the Social Democrats and in an endeavor to thwart their ambitions, he set up this plan. But, as is common in politics, his scheming backfired, the opposition supported the plan and later used it as a potent weapon against Bismark himself.

Organization: The old "Krankenkassen" insurance societies were incorporated into the compulsory system. These societies had been in existance for years and at the time had many subscribers. Under the new program they continued to handle the funds and details of administration. The Federal Insurance Office was the nominal control and gradually had been assuming a greater degree of control. The present scheme under Nazi domination is unknown to us now.

Scope: At first the insurance covered only the industrial wage-earners, but it has been greatly expanded so that now all wage earners up to a certain income level are included.

This plan combines medical care of all types with sickness benefits. Cash benefits start on the fourth day of illness and extend on up to

twenty-six week, with all necessary medical treatment included. There are, however, some differences in the various localities due to local legal controls, combining with the "Krankenkassen" to limit certain items.

Cost: The worker contributes two-thirds and the employer, one-third to the benefit fund. In addition there are certain contributions by the state, such as special maternity benefits. Undoubtedly, this latter is a big item in "Der Furhers" increased propagation award. Most hospitals are state owned and controlled as is common in most continental countries, but the insurance societies have a large number that they have built and are operating. However, a few private hospitals do exist.

According to Sir Arthur Newsholme's study the cost is 11 marks (about $2.64) per capita per day. This is less than in most of Europe, but it is not a true figure since it does not include the sums added by the government or those recieved from taxation which together probably amount to a 30 per cent addition.

Physician: Doctors work for the government for the most part. The figures are set at about 15% doing only government work, 80% drawing the income from insurance companies and 5% making a living in private practice. (Newsholme)

The relationship between the physicians and the insurance societies is bad. There is a constant struggle by the doctor to handle his patients properly and, at the same time, to meet requirements of the

societies. By this, it is understood that the societies must have a large number of doctors on their pay-roll, acting as watch-dogs, thus forcing the physician to shorten the period of treatment and to keep the cost as low as possible.

If exercised cautiously, such a set-up is a benefit, but as it functions in Germany there is, as Cabot describes it, "continuous guerilla warfare" between the physicians and the societies.

Simons and Sinai point out the relationship between the profession and the societies: "The battle between the societies and the medical profession has been practically continuous for fifty years and shows few signs of cessation. This conflict centers around three issues which each side considers vital: First, the amount and method of payment for medical services: Second, 'lay control' over 'economical prescribing', 'free choice of doctor', and 'excessive practice'; and Third, granting certificates of incapacity to work." (Cabot)

FOREIGN SYSTEMS: GREAT BRITAIN

Government: In considering the facts of medical care relating to increased control by the central government, it behooves us to make a rather thorough study of the British experience. As the political units of the world are compared to the republican democracy of United States, there is none that is closer then England's Royalist republican government.

As a whole, our temperment, traditions, customs and attitudes are

more like the British than any other country, save the Dominion of Canada. True, many may say the resemblance is slight, but it cannot be denied, if only because of common language, that we understand "John Bull" far better than any of the other national groups, This indicated by the great interest, and in some circles, apprehension concerning the recent Beveridge report and its implications.

The British system of government may be described as democratic, modern usage, based upon representative elected by adult suffrage. The legislative branch consists of the House of Lords, the seats being filled by inherited right, and the House of Commons, chosen at the general elections.

Commons is far the more powerful group. A party government is centered around the Prime Minister, the leader of the party in power. He directs the general course of the commonwealth as long as his party and its measures are approved by the majority. This type of party control often leads to rapid changes of leadership which, if it were the total power, would lead to an unstable government. However, the governmental functions are operated through local bodies selected by Civil Service with a permanent persionable tenure of office. Naturally these servants may be ousted for criminal acts, but they are not subject to the changes in parties and to that extent are non-political. This tends to create a position to which men of great ability and subsequently great experience are drawn, making possible a stable career in governmental functions.

Anyone familar with the "political plum" system in United States will recognize that this difference is vital. Our Civil Service applies only to minor offices and therefore makes it impossible to offer a career in practical government to men of ability, This is a point of considerable significance, when we come to consider the application of the British system to the United States. Also, such an understanding of the practical differences in governmental policy is necessary to appreciate the position of the medical profession in relation to compulsory health insurance

Practitioners: The General Medical Council was created by the General Medical Act of 1858, "An act to regulate the qualifications of practitioners in medicine and surgery." (Cabot) Although somewhat modified later, it does create a control over the men practicing the art of medicine. It sets up a register of qualified practitioners in the United Kingdom and the British Empire. (Cabot) Only these qualified men may collect fees by legal processes and these men only may hold medical appointments or legally sign any certificate required by an act of Parliment. Specifically it does not prohibit any person from the practice of medicine, but it makes it very difficult to proceed without qualifications. In such a system violaters of medical ethics can be brought before the General Medical Council and tried, and on conviction certain penalties may be imposed.

The British Medical Association is a voluntary organization and its functions are quite the same as our American Medical Association.

The Medical Officers of Health may be compared to our public health officers. However, they may be appointed either by the Ministry of Health, usually full-time officers and removable only for misconduct and are pensionable, or they may be local practitioners on a part-time basis, responsible to the Medical Officer of the county area. They have a more secure tenure of office than do their American counterparts, but perform about the same functions.

Hospitals: A comment on the hospital system is pertinent as hospitals are becoming more important in medical practice in all countries. Five general types of hospitals may be described; the voluntary, public, nursing home, cottage and convalescent.

The voluntary hospitals, about 847 of them functioning, (Cabot) are or were supported mainly by philanthropy. They have a tremendous out-patient service similar to the charity dispensaries in the United States. Since the first World War these have been forced to rely more on patients fees and government support. Many of these hospitals are adding new wings and are changing their policies because they are carrying the great burden of the National Health Insurance business. The new wings provide for private patients, who have come to the voluntary hospitals, seeking care by the "cream" of Englands physicians. An explanation of the last statement lies in the fact that the voluntary hospitals have staff prestige and are teaching hospitals, such as Guys, St. Thomas, Kings College and many others.

Public, municipal and county hospitals may be discussed together,

They had their origin in the Nineteenth Century Workhouse Infirmaries and in other Poor Law Institutions. (Orr & Orr) The survey of these hospitals by Orr and Orr, who seem to have done the most thorough job here, leaves the impression that these hospitals very in their quality. Many are highly satisfactory and have excellent services. They are patronized now by many of the participants in the National Health Insurance. Such hospitals are being rebuilt and modernized to help meet the needs which do exist and which are far from being taken care of adequately.

Nursing homes are the private hospitals of the well-to-do. (Orr &Orr) They are much more expensive than the private hospitals in the United States but their quality does not always measure up to their price; although many are very modern.

The cottage hospitals are a relatively new inovation and seem to be very popular, both with the medical profession and the patients. Such hospitals are small, more or less community concerns where the general practitioner may send patients who require competent medical and nursing care. A good many of these are available to both private and National Health Insurance patients.

Conspicious by their absence in the United States is the English Convalescent Home. Here the patient, nearly well and not actually a hospital case, but in need of rest under supervision, may be sent for a fortnight or so. These are truly for convalescent care and not for chronics, and fillaa much noted gap in medical care.

History: When studying such a system of medical care, especially

considering the applicability to our own country, it is necessary to understand the conditions of Great Britain at the time of the institution of National Health Insurance. The enviroment encountered by a new political move is most important in shaping its future course, just as environment affects the future of an infant.

Living in Britain at the turn of the century was at a much lower standard than we have ever encountered in the United States. The congestion was tremendous, being greater in the poorer districts. A poor district citizen had a standard of living far below our worst slums of today and the number of people in that classification was large. We must remember this was in the middle of the exploiting regime of the Industrial Revolution and in a country which was crowded before the advent of the great industrial centers. Another factor was the development of the Friendly Societies of the day, which in 1904 had a membership of 5,700,000 which is more than one-third of the number entitled to the benefits of The National Health Insurance in 1930. (Cabot) This was a contract system of medical care plus medicines, the contracts paying from 3_s to 4_s (75¢ to $1.00) per member per year. (Cabot) In his analysis of the Friendly Society medical care of that time, Dr. Cabot states in "The Doctors Bill" that the system was unsatisfactory for two reasons: "In the first place, the membership tended to include chiefly the careful and provident people, whereas the careless and improvident were likely to be either wholly without medical care or dependent upon medical service provided by the Poor Law authorities. In the second place,

because of the competition among psysicians for this work, their compensation was likely to be small; their number of patients large; and the temptation to do shipshod work great."

National Health Insurance: The National Health Insurance was an outgrowth of an investigation of the above conditions which came out as a report of the Royal Commission on the Poor Laws in 1909. The act was prepared under and forced through Parliment by Mr. Lloyd George, then Chancellor of the Exchequer. It was violently discussed and more violently opposed by the British Medical Association, which had not been given much audible warning as to its implications. As to the relationship of the British Medical Association, and to the Act since its birth, we will reserve comment.

Scope: The Insured Population covers four income groups.

1. Public Assistance (Poor Law) group. In 1935-'36 there were 1,317,825 or 3.2% of the population represented. Of these 175,000 were insured under Unemployment Insurance ("The Dole").

2. Insurance Income Group includes persons earning up to 250 pounds ($2,500). In this catagory are workers in England with 15 to 20 million dependents. They represent 75 to 80% of the population.

3. The "Black Coated Group" corresponds to our "white collar" group, who earn $1100 to $1400 a year. Even so this group may be in distress due to a long illness of the wage earner. They are not able to benefit from National Health Insurance, but do take advantage of other forms of medical and hospital contributory schemes.

4. Independent Group: This includes from 3 to 5% of the population; earning about 1000 pounds (4500 dollars) yearly.

National Health Insurance then is a compulsory and contributory scheme for virtually all wage earners, who, with their dependents comprise a third of the entire population.

Finance: The contributors arethe workers, the employers and the State. The workers contribute equivalent of 10 cents a week and the employers the same. The State bears expense of administration and contributes about one sixth of benefits.

The employer buys at the Post Office, stamps worth 20 cents each and places one on each worker's card every week, taking one half the cost of one stamp from the wages for that week.

Benefits: There are two types of benefits, medical and cash. The former includes the doctor's care and such medicines as may be prescribed. The latter includes (1) Sickness benefits; cash payments which begin on the fourth day of illness and may last for 26 weeks if the worker is certified by his doctor as unfit for work during that period. The amount paid is 16_s a week for men, 12_s a week for unmarried and 10_s for married women. This is the minimum. (2) Disablement benefit, also cash, amounting to one half the sickness benefit. This is paid for periods of incapacity beyond 26 weeks to an indefinite period. (3) Maternity benefits consist of two pounds to an insured man whose wife has a baby, if the wife is herself insured they recieve a total of four pounds.

Additional Benefits: Additional Benefits of both sorts may be

enjoy, if the finances of the state-approved Societies, who administer the benefits, warrant it.

The following additional benefits are permitted by the Ministry of Health which is the State agency for administering the National Health Insurance Act: Care of eyes, and teeth; hospital and convalescent care; (usually in the country or at the sea-shore) Home nursing care; services of specialists as consultants etc.

The Doctor: Any licensed physician may take on a so-called "panel practice." In fact the great majority of general practioners in Great Britain are insurance pratcioners; (i.e.) Panel doctors, who may or may not combine private with the panel practice. A young doctor usually buys or works into an established practice which includes a panel. He agrees to maintain a surgery (office) and to keep regular hours for seeing his patients. If he is absent, he must provide a substitute, He also agrees to keep clinical records of his patient's sicknesses and to record all consultations and visits to the homes. He must also issue certificates weekly, for those patients who are unable to work, up to the Final Certificate when the patient is either able to resume work or is places on the disabled list. These certificates are the insured person's claim for sickness or disablement benefits.

The "'panel doctor' is obliged to give his patients only such services as 'are within the competence of the average General Practitioner.'" If he is trained to offer specialist services as well, he may charge for these, if he has permission from the local Insurance

Committee.

The average panel is around 1000 patients. They vary from a few dozen to a maximum of 2,500. The doctor receives a "capitation fee" of 9s or $2.25 per year for each insured person, regardless of whether he sees him at all during a given year. The average panel of 1000 persons therefore yields an income of $2,250. With an industrial practice with the maximum of 2,5000 persons the doctor earns $5,500. And if in addition he has a private practice his income may reach much higher figures.

The chemist who fills the doctor's prescription, forwards a copy to the local Insurance Committee, where the cost and the amount due the chemist is calculated. The chemist receives a set fee for prescribing plus a reasonable profit on the drugs used.

The Approved Societies: Instead of "taking out insurance" a worker joins an approved society. There are four varieties of societies recognized by the law as legal agents for handling the non-medical aspect of Health Insurance: (1) Friendly Societies; (2) Trade Unions; (3) Corporations: (4) Industrial Insurance Companies.

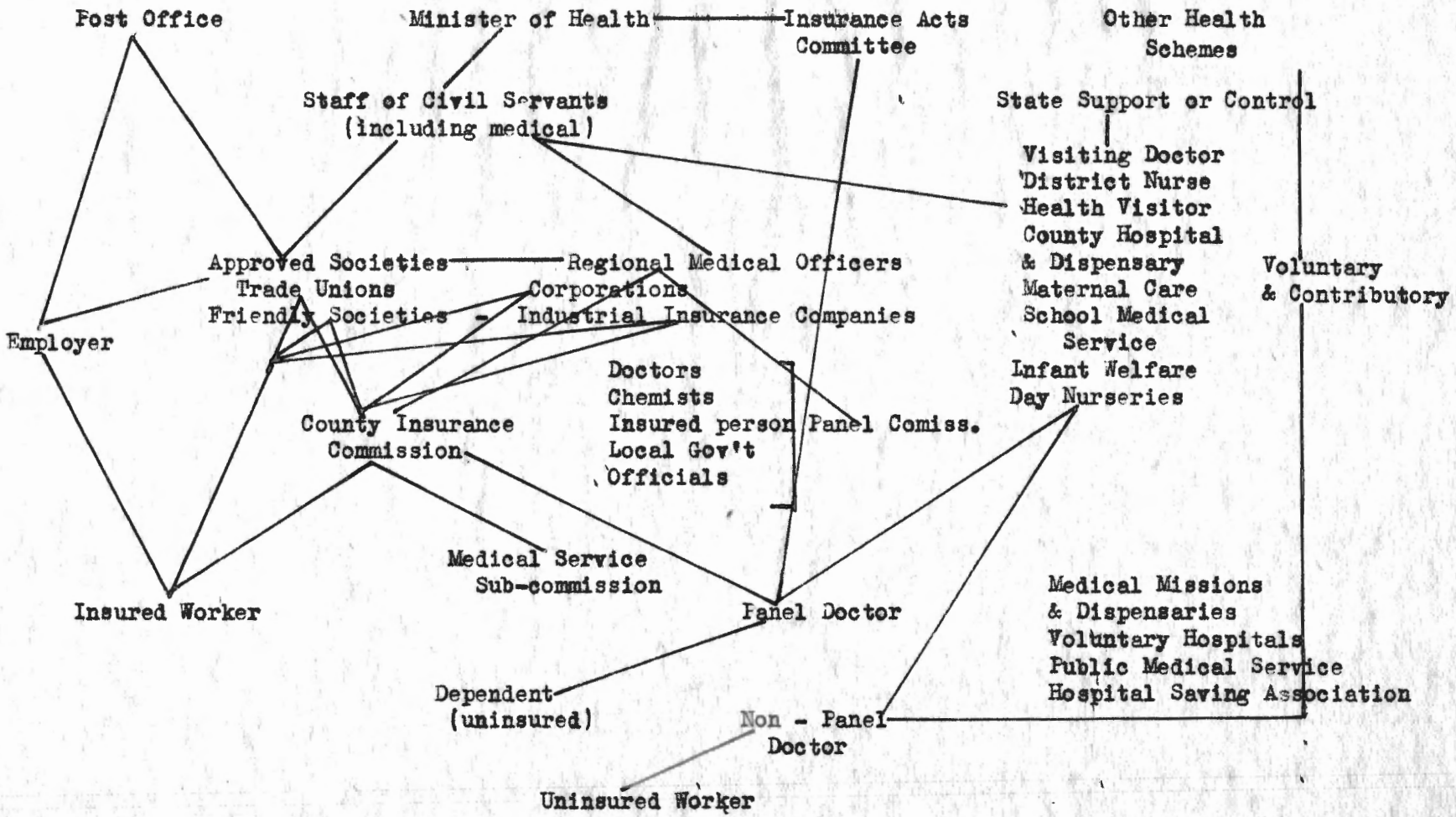
Turning now to other health agencies to which the insured person may supplement his benefits under National Health Insurance. Sometime his resources are so limited that when sickness overtakes the bread-winner, the sickness benefits are far from adequate to support a family and he is forced to turn to the Public Assistance or charitable institutions. Most important, at least until recent times, are the so-called

"voluntary hospitals", in meeting the needs of the indigent sick.

Municipal and County Hospitals: An insured person may take advantage for himself or his dependents of those facilities in voluntary and in tax-supported hospitals, paying only in accordance to his means. Many insured families, however, prefer to contribute to various hospital and sickness schemes, other than National Health Insurance, thus avoiding the red-tape as well as the stigma of public assistance. Some thirty to thirty five per-cent of public hospital patients finance their hospitalization through the Hospital Saving Association or other contributory schemes. One such is the "Penny in the Pound Fund" of Liverpool. The 300,000 members of this scheme contribute one penny per week for each pound of their wages. Workers earning up to 6 pounds a week if married, and with one or more dependent children, are eligible.

Management: This is under three authorities; The Ministry of Health, The Insurance Companies and the Approved Societies. In brief, these three authorities operate in the following manner. (see chart # 1 for aid in interpretation) The Minister of Health appoints a committee, separate from the Insurance Societies, to deal with medical benefits. A Insurance sub-committee is set up in every county or county borough, consisting of from 20 to 40 members and operating under definite regulations promulgated by the Minister of Health. (Christie) The "panel" of all registered physicians making application to participate in National Health Insurance is established by this sub-committee.

The patient-physician relationship works in the following way.



National Health Insurance Plan

CHART I

Patients are allowed free choice of their Doctor and the physician may refuse any patient. The doctor may withdraw from the "panel" at any time.

"Cash benefits" are separate from medical benefits and are controled by the Insurance Companies. However, the physician has to certify the patients disability for cash benefits, which causes some friction. Investigators keep check on the physicians and rate them according to their ability to cut down the length of disability.

FOREIGN SYSTEMS: NETHERLANDS

Another of the European countries which has a form of medical insurance is Netherlands, that small, flat and partially under sea-level land with a population of about seven and one-half millions.

Benefits: Medical benefits are paid for by a voluntary contribution system. There is no allotment for compensation. All of the payments are for actual medical care to the insured.

Administration: The administration of the program is under the Central Council of Public Health. This Concil consists of seventy unpaid members. This is a large body and might be rather unwieldy, or as expressed by Sir Arthur Newsholme, "It must, I think, unless skillfully managed, act as a clog on prompt and necessary official activities." The Council advises and assists the government in dealing with health problems. Its president, a physician, is director-general of the Public

Health Service. He has five chief official inspectors under him who supervise local sanitation and medical care. They control various phases of other allied problems by local supervisors. According to Newsholme, the care of the indigent is not very highly developed by Netherland's program.

A variety of groups offer sickness funds, and they are listed in six catagories: (1) General societies with local branches; (2) Sick-fund companies which are on a commercial basis; (3) Funds managed by the employer, somewhat similar to funds which exist at the present time in the United States; (4) Benevolent funds concerned chiefly with people close to the line of destitution; (5) Mutual benefit funds founded and carried on by a physician or groups of physicians. (Cabot) The management of these various groups differs a good deal, but all follow about the same pattern to their end results.

Cost: The upper income level above which members will not be accepted is about 2000 guilder ($300). (Cabot) Contributions vary from 12 to 24 cents per week for a family and usually include the children.

Physicians: Physicians and druggists are paid in various ways, most often by fixed rates from the family. There is no free choice of Doctors outside those in that particular fund, and because these funds are usually small organizations there is actually very little choice.

Accident Insurance: Industrial accident insurance is separate and compulsory, at the expense of the employers.

Hospitals: Hospital care here, as in most countries, provides

various types of accomodations. Arrangements are voluntary and quite often on pre-payment plan, separate from the medical benefits. There is a bed ratio of about 1-3000 for hospitals over the country, but these are poorly situated, with variations from 1-5000 to 1-1000.

All in all Netherlands has good general medical care, at relatively modest cost, for a large proportion of the population under entirely voluntary organization. (Cabot) However, the coordination between hospitals, specialists and general medical care is behind that of most countries.

FOREIGN SYSTEMS: DENMARK

Concerning the success of voluntary sickness insurance, there is no country which has set a better example than Denmark. Voluntary, as used by the Danes is a rather tricky work, especially concerning its application to health insurance, because this voluntary system is backed up by left-handed compulsion. The person who fails to join a sickness club and during sickness is forced to ask for public assistance, loses his right to vote, his right to marry without special permission and his annuity for old age. However, whether voluntary or compulsory, the Danish method is worth studying.

Origin: The program is controlled by the National Board of Health in the Ministry of the Interior. A physician appointed for life and with a right to a pension directs the board. In a country of about 3,5000,000 population it is quite within the realm of good business practice for a single board with district supervisors to adequately

manage the Health program, and that is what happens here. District Medical Officers have life tenure and are therefore less susceptible to the wiles of the politicians.

Insurance societies handle the policies and these are paid for according to the income. Higher incomes pay relatively more for the insurance.

Doctors: Nearly all of the 2500 physicians belong to the Danish Medical Association which deals directly with the state. (Cabot) This considers salaries for hospital officers and the methods and rates of payment to and from the insruance companies, doctors and patients. All medical personnel are trained in the medical school and hospital of Copenhagen, in a course coverning seven years.

Benefits: As stated, all citizens wishing to retain their rights, must belong to an Insurance Society. The patient gets complete medical care plus the benefits of an obligatory disability insurance. Old age insurance is universal for all members of insurance societies as they reach the age of sixty-five. (Cabot) Insurance for invalidity is compulsory between ages of fourteen and forty. All of these functions require about a 30 per cent contribution to the insurance societies by the government. (Christe)

Hospitals: Hospitalization facilities in Denmark are highly developed, at least when compared to the rest of Europe. There are 9.3 beds per thousand of population. (Cabot) All countries are required to have from 1 to 3 hospitals, as necessary for adequate care, thus

giving rise to a fairly well distrubuted supply. Medical staffs are full-time and part-time. All members being state officers and on salaries. The hospitals are supported by taxation and charges to patients graduated to their individual means. Medical benefit society members pay half the regular charges. All classes use the same hospitals.

One important showing, according to Newsholme, is that in Denmark, at least, very satisfactory hospital work can be carried out on a salary basis.

Physician-Patient Relation: Fees to physicians vary in the outlying districts, but are controlled under the set-up by the Danish Medical Association in cooperation with state and insurance societies. Most physicians are believed to be making a decent, though not at all extravagant, living. Private practice may be carried on in addition to insurance work. The choice of physician by the patient is limited to the members of the particular insurance group and, except in Copenhagen, the choices are few.

FOREIGN SYSTEMS: FRANCE

France passed the law for compulsory health insurance in 1928, but the plan has not been carried out long enough for any accurate evaluation of it to be given. However, one item of interest in the French plan is the basis of payment for medical services. The physician's charges are all made on the foundation of simple "Medical Act", that is, official consultation, All other "Medical Acts" being multiples of it. (Christe)

UNITED STATES SYSTEMS: UNIVERSITY HEALTH SERVICES

As we survey the various special methods for providing group medical care in the United States, it is easier to begin with a rather familiar and close-to-home example.

Method: Many University and College group medical services have been started and are being carried on to provide adequate health care for the student at a set pre-paid rate. Some of them provide partial care, such as preliminary physical examination and care of injuries due to accidents in the required physical exercises and sports. However, many have gone far beyond this and actually provide complete medical care.

Costs: According to the report of the Committee on the costs of medical care, studying six such University services, four institutions had medical services which were practically self-supporting. The student feew ranging from $9.16 to $16.78 per student annually, Others had some additional funds provided, especially the endowed institutions. Although this is a narrow field and the majority of the patients are young and health, the evidence of a workable plan without great individual cost is an example which must be remembered.

UNITED STATES SYSTEMS: INDUSTRIAL MEDICINE

First a clarification of the term "Industrial Medicine" is necessary. It may mean two very different things: (1) a description of a specialty or subdivision of medical practice, such as general

supervision of the medical care in a certain industry by a specialist trained in private medicine, but hired by the certain industry in a supervising capacity; or (2) It may describe the medical care provided for the personnel in connection with industry.

Industrial medicine in the first sense is gradually becoming a part of the second, so we may consider for the most part, the second type of industrial medicine, making brief references where necessary, to the first.

Scope: Practice of industrial medicine was started primarily on an economic basis. Certain business men realized that they could save money by providing a permanent medical service which would do the following: (1) give adequate physical examinations to exclude the physically handicaped; (2) provide periodic physical checkups to keep up efficiency and help prevent avoidable accidents and slow-down of work; (3) give prompt and satisfactory care of minor industrial accidents; (4) improve general plant hygiene, ventilation and recommend safety measures. It was found that the hiring of specially trained medical men to manage this service greatly improved the results and thus developed another specialized division of medical practice.

Industrial medicine was given great impetus by the passage of Workman's Compensation Laws, which will be discussed under a separate heading. Several separate examples of industrial medicine will be described briefly in order to present a picture of this important variation in American medicine.

UNITED STATES SYSTEMS

ENDICOTT JOHNSON; INDUSTRIAL SYSTEM

Williams brief description of one type of industry and its meeting of the medical problem follows: "The Endicott-Johnson Corporation's Medical Service was inaugurated in 1913 to meet the requirements of the Workmen's Compensation Laws of New York State, and in the beginning it provided only for first aid of injured workmen. It now includes care for non-industrial injury and ordinary sickness. There are three medical centers, two maternity hospitals, two nose and throat hospitals, all fully staffed. In addition, employees are cared for in local community hospitals, at the expense of the company. No monetary contribution toward the cost of any of this service is made by the employees."

It must be realized that this company is a large, well organized group with the financial assets to inaugurate a plan such as this one. Not many industries are in a position to handle such a load.

Staff: There was, in 1928, a staff of twenty eight full-time physicians. Of these,.fifteen were general practioners, four were partly specialized, and nine were specialists. (Cabot) Outside consultation is encouraged where the need is evident. Special work, such as orthopedics and urology is generally preformed by outside physicians. Salaries vary from $3000 to $12,900 net. (Cabot)

Patient-Physician: In studying the evolution of this service, it is evident that it was expanded at the request of the employees who stated that they could not afford outside medical expense. The patient has the right to choose his own doctor within the company and within

the limits of the physician's capacity. However, the rule is for the patient to remain under the same physician's care. (Cabot)

Payment: The method of payment is peculiar as it is quite possible that the cost of giving this service is passed on to the consumer. Actually it is an indirect method of taxation.

UNITED STATES SYSTEMS: HOMESTAKE MINING COMPANY

Another example of medical service provided for the employee by employer is the Homestake Mine Medical Service. Although not so complete in the range of service, this company does offer medical care to employees and their families.

The service was instituted in 1910 to provide office consultation, home service, hospital service and medicine, but no dental care of home nursing.

Cost: Probably the most enlightening facts about this industrial medical group are those related to the cost as analyzed by Cabot, who says, "The total cost, in 1930, was $79,325,63 or $14.88 per eligible person. The portion of the cost which should be allocated to industrial injury---that is to say coming under requirements of the Workmen's Compensation Act, was $10,630.00 or $1.99 per capita of employees. It is of some interest to compare these per capita costs with medical charges paid by other members of the same community to physicians in private practice. There is a basis of comparison here in a group of about 9,000 families not coming under the group cared for by the Homestake

Medical Service. Study of this point develops the fact that for families with an income of from $1200 to $2000, the fees paid to private physicians are somewhat less, while families having an income of $2000 to $3000 pay somewhat more than the cost of the Homestake Medical Service. However, the family cared for by the Service gets about six times the number of office calls and from 40 to 90 per cent more home calls than does the family employing private physicians. If the families cared for by the Medical Service had been charged the rate of fees customary among private physicians in this region, the expense to the Homestake Mine would have been $175,378.00 instead of $70,977.56."

UNITED STATES SYSTEMS

COMMUNITY MEDICINE--ROANOKE RAPIDS, NORTH CAROLINA

Although some community health service projects are closely related to industrial medicine, it is worthwhile to examine the general plan. A typical community, in an industrial area, might be Roanoke Rapids, North Carolina. This community lies in a state which has one of the lowest doctor to patient ratio in the union, being about 1 doctor per 5000 patients.

Service: A service was organized by five industrial companies in the city for their employees. Later it was extended to include a group of teachers and a small group of nurses. It also offers the same medical service to other residents of the city and county. This service offered, includes hospital care, office visits, home calls and laboratory

tests. It lacks dental care, drugs or expert care in diseases of the ear, nose and throat.

Funds: The physicians and visiting nurses are paid by the cooperations, which also pay certain fixed charges at the hospital. Employees pay twenty-five cents a week which is deducted from their pay checks. The 130 teachers and 13 nurses pay $25.00 a year and $24.00 a year respectively. Other community residents, who wish to take advantage of the service, pay on a regular fee-for-service basis.

Staff: The medical staff consists of five physicians and three visiting nurses. The average net income in 1930 was $8,409.00. ?

Cost: In 1930, the total cost of operation was $226,264.00. The cost per capita to the well people was $17.63. (Falk, Griswold, Spicer)

According to Cabot, who analyzed the figures of the above writer, the cost was about 35 per cent less than if the services were purchased in the regular unorganized way.

The picture presented here is not as rosy as we might be led to believe, because the Roanoke Rapids plan does not provide complete service. Moreover, the financial contributions are definitely based on the solvency of the companies participating. On the other hand, it cannot be denied that the medical service provided is far superior to that offered in most southern mill towns.

UNITED STATES SYSTEMS: WORKMENS COMPENSATION

History: Although it was not recognized for a long time the indus-

trial revolution began an evolution in the practice of medicine. Before the advent of the great industries of our mechanical age, the employer-employee relationship was close, and common-law provided that the injured servant be cared for by the master.

With industrilization and its remote control of the worker by the usually money-minded manufacturer, there developed three new principles in common-law litigation. According to Cabot these may be described as follows; "The first was the doctrine of 'fellow servant' under which it was held that where injury resulted from the fault of a fellow servant, the employer could not be held liable. The second defense was the doctrine of 'the assumption of risk', under which it was held that an employee assumed the risks of the occupation. Finally, there was a doctrine of 'contributory negligence', under which the employee was required to show that the accident was not the result of his own carelessness. As a result of these defenses it commonly was impossible for an injured employee to recover in the courts."

The first remedy for this situation was just about as malignant as the disease. When the employer's liability was established by law, starting with the state of Massachusetts, in 1886, (Christe) the employer quickly transferred his risk to the insurance companies. These companies, through rather unscrupulous methods, soon had control of the situation and as a result of shrewd adjusters etc., were retaining a great proportion of the all too few compensation fees. This condition persisted for about twenty years, getting worse all the while, until public agitation forced the subsequent changes in legislation. Starting

in 1910 the laws were changed, state by state, through another period of about 20 years, so that the industry itself, not the insurance company, was responsible for carrying the burden of the care of the injured.

Although the states and their laws covering compensation insurance differ in many way, there is a general pattern which may be presented in brief.

Administration: Nearly all compensations are settled by a commission or board, sometimes a single administrator. This commission is fixed by law and not by court action, and in theory is an adjustment by impartial administrators. To provide against the employer who may not be able to furnish compensation, most states equire the employer to carry insurance. There are, in general, three types of self-insurance: (1) monopolistic state-managed insurance; (2) state-managed insurance in competition with private companies; (3) private companies (depended upon by most states entirely). (Christe)

Coverage: Here too are many variations, but as "The Costs of Medical Care Survey" puts it, "Some laws cover only 'hazardous' or 'extra hazardous' industries and nearly all exclude domestic employees, from farm laborers, casual employees and firms employing less than a specified number of persons."

The type of injuries covered vary some, but there is a tendency toward inclusion of all injuried and some states add the so-called occupational diseases. All states provide a waiting period of from three days to two weeks, during which medical care is provided, but no compensation for wages etc. is provided.

Payment: The cost of medical care and the amount of the compensation is usually set by the state legislature. A few schedule is adopted and in general the profession is required to abide by it. The difficulties are easily seen, and recognized by the various members of the Compensation Courts. This is revealed in the official statement by the Nebraska Compensation Court fee schedule, (1941) which contains this statement, "No hard and fast rules can be applied to all cases. Daily observation by attending physicians or surgeons is not indicated in many instances and will not be approved by the Compensation Court unless the need is truly apparent. Charges will be allowed only for visits commensurate with the requirements and then seemingly escessive must be fully and completely explained to the satisfaction of the Compensation Court." It is obvious that the establishment of a fixed fee schedule for a profession operating on a sliding-scale basis is very difficult. The same difficulty applies in the dealings with hospitals.

Relation of Physician to The Act: Here is probably the most unsavory part of the Compensation Law, As, is common professional knowledge, the laws were regarded with great indifference by the profession. As a result, the laws provide that the employer will designate, in all except very special cases, the physician or surgeon who shall furnish treatment. Also a majority of the commissions are lay courts without satisfactory medical advisors. This, combined with the fact that the members of boards on commissions are usually subject to political influences, makes a rather complicated problem.

The type of insurance control, state, private or mixed, seems to

have little to do with the good or bad function of the laws in each state, as there are examples of all degrees of success with each plan. Recently there has been a trend toward closer cooperation between the state commission and the active state medical societies. "In New York State, for example, great improvement in administration has been brought about by intelligent agressive work of the state medical society." (Christe)

All in all, it is generally felt that despite numerous flaws in the laws and resultant practical difficulties, the Compensation Laws are a step in the right direction. Disagreement on the method administration and the position of the medical profession in relation to the administration make it impossible to attain the benefits hoped for.

UNITED STATES SYSTEMS: HEALTH INSURANCE, VOLUNTARY (PRIVATE)

Health insurance, as offered by the large American Insurance Companies, can be either compulsory or voluntary. The only compulsary form in the United States is emboided in the Workmen's Compensation Law.

Voluntary health insurance policy holders have increased many fold in the last decade, and as a result, more companies are willing to write policies at rates that are payable by the majority of the middle wage group. Nevertheless, the cost is still beyond many of this group and definitely beyond the members of the lower bracket. An important fact in dealing with voluntary health insurance is that it is usually the provident, frugal type of worker who takes advantage

of the insurance. The rest of the workers will rarely subscribe voluntarily, being content to keep the money and take a chance.

Type of Policy: The standard accident and health policies written by many American Insurance Companies simply pay a cash benefit to cover the loss of income due to disability from injury and disease. (Christe) They are paid for by weekly, monthly or yearly premiums. In a good many cases the employer makes such policies available to his employees, either by paying all the premium or more often by sharing the cost and deducting the employee's contribution from his wages.

HOSPITAL SYSTEMS: BLUE CROSS

The Associated Hospital Service of New York is a good example of the so-called "Blue Cross" hospital plan.

Purpose: The purpose of this system is to provide a method for insuring complete hospitalization paid for on a flat rate, pre-payment basis. It is a voluntary organization.

Organization: Control over all policies lies in the Board of Directors representing the hospitals, the medical profession and the public. There are six physicians appointed from a list approved by the local county medical society; six hospital representatives appointed from a list approved by the Greater New York Hospital Association, the New Jersey Hospital Association, the Mid-Hudson Hospital Association and the Westchester Hospital Association; and six representatives

of the public. (Kelly)

Scope: The plan provides all-inclusive hospital services for all participants using semi-private or ward accomodations.

Payment: All members pay a flat rate and recieve the same benefits.

UNITED STATES SYSTEMS

THE FARMERS UNION COOPERATIVE HOSPITAL, ELK CITY, OLKAHOMA

The Farmers Union Cooperative Hospital of Elk City seems to be one of the earliest examples of a successful American medical cooperation. It is a cooperatively owned and managed hospital and group clinic. It provides its members and their dependents with complete medical and dental services on a flat monthly or annual fee basis, with minor supplementary charges based on the services recieved. (Rorty)

Administration: There are five directors elected by the stockholder who comprise the board of management. They employ a business manager for the hospital and the director of the medical staff.

Coverage and Cost: Three physicians and two dentists constitute the staff, or did in 1936. (Rorty) There is no extra charge for consultations, physical or laboratory examinations, surgical operations or obstetrical care. Stockholders and their families are charged $1.00 for the first ^ days hospitalization; $2.00 per day thereafter. Private nurses for three days are provided if deemed necessary by the attending physician. All dental care is free. There is a charge for anesthetics and operating room supplies, also for X-ray films (other than dental); $3.00 for one and $2.00 for each additional film. Extra

charges to stockholders are made as follows: Home calls, $1.50 plus 25 cents per mile. Other residents of the community may use all the facilities on payment of the regular fee charged for similar services in the community. (Rorty)

Physician: From Dr. Shadid's "Principle of Cooperative Medicine", an extract will serve to give one point of view on the physicians status:

"1. Under our setup, the doctors completely control the professional end of the work free from interference of laymen and have as much to say about their compensation as they do in private practice."

"2. Our compensation as doctors, during the drough and the depression, compare favorable with the income for similar work before the depression. For we do no more work than we did before that time."

"3. We are free from economic matters, including bookkeeping, collections, overhead, etc."

"4. We take a month or so off each year on pay."

"5. The interests of the doctors are one and they cooperate whole heartedly with each other without any thought of jealousy or personal advantages, and we enjoy our relations professionally and socially, as never before under individual competitive practice."

"6. Our patients come to us early when in need of operation or hospitalization."

"7. We enjoy their respect and confidence for they know that our advice is not tinged with personal interest, but wholly for their own good."

"8. We do enormously more good, which is after all the chief object of the profession. The profession and the public are benefitted, and no one else is hurt."

History: A few words of history in connection with this project will help to clarify some of the ideas presented. Dr. Shadid is and has been for many years an admitted socialist, but it is also true that his practice of medicine has been ethical and undoubtedly is of average or better than average quality.

Since the beginning in 1930, it has been necessary to enlarge the facilities three times, and the number of participating families has increased at least five fold. The Oklahoma Medical Society has waged a long battle to discredit Dr. Shadid, but up till now it appears to have been unsuccessful.

PART II

AN ANALYSIS OF THE OUTSTANDING PROPOSALS FOR FUTURE MEDICAL CARE

FOREIGN PLANS: BRITISH-BEVERIDGE PLAN

As stated in the introduction, this paper is the result of a discussion of The Beveridge Report and its medical implications. At that time, the author's acquaintance with various proposals for social change was quite superficial. As the study progressed it became evident that the report by Sir William Beveridge is an epic. It may be that this is an overestimation, but it cannot be denied that here is a doctrine of living as comprehensive and as thoroughly presented as any since that of Karl Marx. Not only has it profoundly affected the social, economic and political thinking of Great Britain, but it is having the same effect on the other members of civilization in this chaotic, bewildering era.

All this may be regarded as political propaganda, but judgement should be witheld until one has studied the plan and read a great number of the analyses, criticisms and various sundry comments on it. This proposal must be treated like any new man or woman that one meets; The first impression may be bad or good, but it is only after careful observation and mutual participation in the activities of life that one is in a position to judge true merit.

The following is a very cursory presentation of the outstanding items in The Beveridge Report with special emphasis on the medical proposals. All quotations in this summary are directly from the Beveridge Report. In order to understand the effect on medicine it is necessary to understand the whole plan. For that reason this will be without details such as costs etc., but will emphasize general text.

Explanation of some of the proposals and reasons that they are deemed necessary can be obtained only by reading the Report itself.

Reasons for Beveridge Plan: The Inter-departmental Committee on Social Insurance and Allied Services was appointed in June, 1941 by the Minister without Portfolio, to study some of the problems of reconstruction. The terms of reference required the Committee "to undertake, with special reference to inter-relations of schemes, a survey of existing national schemes of social insurance and allied services, including Workman's Compensation and to make recommendations." The first duty was to survey and the second to recommend.

Results: (a) It was found the Britain equals or surpasses all other countries in the provisions against the many varieties of needs arising from interruption of earnings and other causes that may arise in modern industrial communities. (b) In one important respect only, does it fall short--namely, in the limitation of medical services. This applies both to range of care provided and the classes of people for whom it is provided. It is also defective in dealing with maternity and funeral benefits and the function of the Workman's Compensation Laws. (c) Social Insurance and allied services are conducted by a complex of disconnected administrative organs with different principles and ranges of activity. This causes an overlapping of service and resultant duplication of cost that should be corrected. (d) The limitations of availability of aid during periods of illness, when incomes are stopped, are such that many people working on their own need more protection. Also, the various tests applied to qualify requests

for aid are very inconsistent. An example of the discrepencies is: "An adult insured man with a wife and two children recieves 38/ per week. Should he become unemployed and after some weeks of unemployment he becomes sick and not available for work, his insurance income falls to 18/. On the other hand a youth of 17 obtains 9/ per week when he is unemployed, but should he become sick his insurance income rises to 12/ per week."

Principles Guiding Recommendations: " 1. The first principle is that any proposals for the future, which they should use to the full should be guided by the experience gathered from the past and should not be restricted by consideration of sectional interests established in the obtaining of that experience." "2. The second principle is that organization of social insurance should be treated as one part only of a comprehensive policy of social progress. Social insurance fully developed may provide income security; it is an attack on Want."

According to the report there are five giants on the road of reconstruction. These are: Want, Disease, Ignorance, Squalor and Idleness.

"3. The third principle is that social security must be achieved by cooperation between the State and the individual. The State should offer security and contribution. The State should, in organising security, not stifly incentive, opportunity, or responsibility in establishing a national minimum, it should leave room and encouragement for voluntary action by each individual to provide more than the minimum

for himself and his family."

Way to Freedom of Want: Working from a review of existing schemes of social insurance and allied services, the Inter-departmental Committee outlines the way to freedom from Want as primarily a diagnosis of Want and secondarily abolition of those factors found to be causing Want. Having proved to their own satisfaction that there were factors causing Want that could be eliminated, they drew the following conclusion. "Abolition of Want requires a double redistribution of income, through social insurance and by family needs."

Briefly the approach through improvement of State Social Insurance involves progress in three directions; (1) To increase the scope so that the plan covers people now excluded; (2) Extension of purposes to cover risks now excluded; (3) And by raising the rates of benefit.

Family needs can be covered by income adjustment so that there is adequate income during periods of interruption of earnings. This includes reallottment of insurance benefits to provide for child allowances. Beveridge believes that application of the above factors namely; social insurance extension and children's allowances is the simplest way to abolish Want. Two other factors are considered in the overall picture as being basically important. Great Britain is gradually becoming a country of old people, of the retirement age, due to medical advances which tend to prolong life and to decrease birth rate. In order to remedy this situation it is advisable to plan for postponement of retiring age and to aid the people in a program to increase the birthrate. This is provided for under social insurance and children's allowances.

Summary of Plan For Social Security: The main feature of the plan is provision by social insurance against interruption and destruction of earning power and for special expenditures arising at birth, marriage and death. Six fundamental principles are listed: (1) flat rate of subsistence benefit; (2) flat rate of contribution; (3) unification of administrative responsibility; (4) adequacy of benefit; (5) comprehensiveness; (6) adequate classification. These six should, if properly applied, make Want unnecessary.

The main provisions as listed in the plan are:

(1) "The plan covers all citizens without upper income limit, but has regard to their different ways of life; it is a plan all-embracing in scope of persons and of needs, but is classified in application."

(2) "In relation to social security the population falls into four main classes of working age and two others below and above working age respectively, as follows:

I. Employees, that is, persons whose normal occupation is employment under contract of service.

II. Others gainfully occupied, including employers, traders and independent workers of all kinds.

III. Housewives, that is married women of working age.

IV. Others of working age not gainfully occupied.

V. Below working age.

VI. Retired above working age.

(3) "The sixth of these classes will receive retirement pensions and the fifth will be covered by children's allowances, which will be paid

from the National Exchequer in respect of all children when the responsible parent is in receipt of insurance benefit or pension, and in respect of all children except one in other cases. The four other classes will be insured for security appropriate to their circumstances. All classes will be covered for comprehensive medical treatment and rehabilitation and for funeral expenses."

(4) "Every person in Class I, II or Iv will pay a single security contribution by a stamp on a single insurance document each week or combination of weeks. In Class I the employer also will contribute, affixing the insurance stamp and deducting the employee's share from wages or salary. The contribution will differ from one class to another, according to the benefits provided, and will be higher for men than for women, so as to secure benefits for Class III."

(5) "Subject to simple contribution conditions, every person in Class I will recieve benefit for unemployment and disability, pension on retirement, medical treatment and funeral expenses. Persons in Class II will recieve all these except unemployment and disability benefit. As a substitute for unemployment benefit, training benefit will be available to persons in all classes other than Class I, to assist them to find new livelihoods if their present ones fail. Maternity grant, provision for widowhood and separation and qualification for retirement pensions will be secured to all persons in Class III by virtue of their husbands' contributions; in addition to maternity grant, housewives who take paid work will receive maternity benefit for thirteen weeks to enable them to give up working before and after childbirth."

(6) "Unemployment benefit, disability benefit, basic retirement pension after a transition period, and training benefit will be at the same rate, irrespective of previous earnings. This rate will provide by itself the income necessary for subsistence in all normal cases. There will be a joint rate for a man and wife who is not gainfully occupied. Where there is no wife or she is gainfully occupied, there will be a lower rate, where there is no wife but a dependent above the age for children's allowance, there will be a dependent allowance. Maternity benefit for housewives who work also for gain will be at a higher rate than single rate in unemployment or disability, while their unemployment and disability benefit will be at a lower rate; there are special rates also for widowhood as described below. With these exceptions all rates of benefit will be the same for men and for women. Disability due to industrial accident or disease will be treated like all other disability for the first thirteen weeks; if disability continues thereafter, disability benefit at a flat rate will be replaced by an industrial pension related to the earnings of the individual subject to a minimum and a maximum."

(7) "Unemployment benefit will continue at the same rate without means test so long as unemployment lasts, but will normally be subject to a condition of attendance at a work or training centre after a certain period. Disability benefit will continue at the same rate without means test, so long as disability lasts or till it is replaced by industrial pension, subject to acceptance of suitable medical treatment or

training."

(8) "Pensions (other than industrial) will be paid only on retirement from work. They may be claimed at any time after the minimum age of retirement, that is 65 for men and 60 for women. The rate of pension will be increased above the basic rate if retirement is postponed. Contributory pensions as of right will be raised to the full basic rate gradually during a transition period of twenty years, in which adequate pensions according to needs will be paid to all persons requiring them. The position of existing pensioners will be safeguarded."

(9) "While permanent pensions will no longer be granted to widows of working age without dependent children, there will be for all widows a temporary benefit at a higher rate than unemployment or disability benefit, followed by training benefit where necessary. For widows with the care of dependent children there will be guardian benefit, in addition to the children's allowances, adequate for subsistence without other means. The position of existing widows on pension will be safeguarded."

(10) "For the limited number of cases of need not covered by social insurance, national assistance subject to a uniform means test will be available."

(11) "Medical treatment covering all requirements will be provided for all citizens by a national health service organized under the health departments and post-medical rehabilitation treatment will be provided for all persons capable of profiting by it."

(12) " A Ministry of Social Security will be established, responsible for social insurance, national assistance and encouragement and super-

vision of voluntary insurance and will take over, so far as necessary for these purposes, the present work of other Government Departments and of Local Authorities in these fields."

Unified Social Security and Changes Involved: The changes believed necessary to carry out the provisions of the plan are set out below.

(1) "Unification of social insurance in respect of contributions, that is to say, enabling each person to obtain all benefits by a single weekly contribution on a single document."

(2) "Unification of social insurance and assistance in respect of administration in a Ministry of Social Security with local Security Offices within reach of all insured persons."

(3) "Supersession of the present system of Approved Societies giving unequal benefits for equal compulsory contributions (combined with retention of Friendly Societies and Trade Unions giving sickness benefit as a responsible agents for the administration of State benefit as well as voluntary benefit for their members)."

(4) "Supersession of the present scheme of Workmen's Compensation and inclusion of provision for industrial accident or disease within the unified social insurance scheme, subject to (a) a special method of meeting the cost of this provision, and (b) special pensions for prolonged disability and grants to dependents in cases of death due to such causes."

(5) "Separation of medical treatment from the administration of cash benefits and the setting up of a comprehensive medical service for every citizen, covering all treatment and every form of disability under

the supervision of the Health Department."

(6) "Recognition of housewives as a distinct insurance class of occupied persons with benefits adjusted to their special needs, including (a) in all cases (marriage grant), maternity grant, widowhood and separation provisions and unemployment or disability; (c) if gainfully occupied, special maternity benefits in addition to grant, and lower unemployment and disability benefits, accompanied by abolition of the Anomalies Regulations for married women."

(7) "Extension of insurance against prolonged disability to all persons gainfully occupied and of insurance for retirement pensions to all persons of working age, whether gainfully occupied or not."

(8) "Provision of training benefit to facilitate change to new occupations of all persons who lose their former livelihood, whether paid or unpaid."

(9) "Assimilation of benefit and pension rates for unemployment, disability other than prolonged disability due to industrial accident or disease, and retirement."

(10) "Assimilation of benefit conditions for unemployment and disability, including disability due to industrial accident or disease, in respect of waiting time."

(11) "Assimilation of contribution conditions for unemployment and disability benefit, except where disability is due to industrial accident or disease, and revision of contribution conditions for pension."

(12) "Making of unemployment benefit at full rate indefinite in duration, subject to requirement of attendance at a work or training centre after a limited period of unemployment."

(13) "Making of disability benefit at full rate indefinite in duration, subject to imposition of special behaviour conditions."

(14) "Making of pensions, other than industrial, conditional on retirement from work and rising in value with each year of continued contribution after the minimum age of retirement, that is to say, after 65 for men and 60 for women."

(15) "Amalgamation of the special schemes of unemployment insurance, for agriculture, banking and finance and insurance, with the general scheme of social insurance."

(16) "Abolition of the exceptions from insurance (a) of persons in particular occupations, such as the civil service, local government service, police, nursing, railways and other pensionable employments, and in respect of unemployment insurance, private indoor domestic service; (b) of persons remunerated above 420 pounds a year in non-manual occupations."

(17) "Replacement of unconditional inadequate widows' pensions by provision suited bo the varied needs of widows, including temporary widows' benefit at a special rate in all cases, training benefit when required and guardian benefit so long as there are dependent children."

(18) "Inclusion of universal funeral grant in compulsory insurance."

(19) "Transfer to the Ministry of Social Security of the remaining functions of Local Authorities in respect of public assistance, other than treatment and services of an institutional character."

(20) "Transfer to the Ministry of Social Security of responsibility for the maintenance of blind persons and the framing of a new shceme

for maintenance and welfare by cooperation between the Ministry, Local Athorities and voluntary agencies."

(21) "Transfer to the Ministry of Social Security of the functions of the Assistance Board, of the work of the Customs and Excise Department in respect of non-contributory pensions, and probably of the employment service of the Ministry of Labour and National Service, in addition to unemployment insurance, and the work of other departments in connection with the administration of cash benefits of all kinds, including workmen's compensation."

(22) "Substitution for the Unemployment Insurance Statutory Committee of a Social Insurance Statutory Committee with similar but extended powers."

(23) "Conversion of the business of industrial assurance into a public service under an Industrial Assurance Board."

Medical Proposals: In the particular field, medicine, in which we are interested, the proposals are generalized leaving the working out of the details to the members of the profession and associated lay workers. Assumption B under Part VI, Social Security and Social Policy, deals with the Comprehensive health and Rehabilitation Services.

As stated in the report, there are two sides to this assumption. First, it covers a nation, health service for the prevention and cure of disease and disability by medical treatment. And secondly, it covers the rehabilitation and filling for employment by treatment which will be both medical and post-medical. It is easy to see that such a program will necessarily call for action both of the department concerned

with health and of the ministry of labour and national services. There is no endeavor to separate these functions in the present report, rather all concerned are to be combined under one head. This an over simplication and more detailed plans will probably have to distinguish between medical and post-medical work.

A coordinated scheme is proposed in which adequate medical care will be readily available with proper emphasis on prevention of disease and rehabilitation. The recommendation that such services be paid for in the form of insurance benefits indicates a desire to put emphasis on the cost and thereby to get the individuals' cooperation in keeping down unnecessary expenditures.

Quoting directly from the Report, "the first part of Assumption B is that a comprehensive national health service will ensure that for every citizen there is available whatever medical treatment he requires, in whatever form he requires it, domicilliary or institutional, general, specialist or consultant, and will ensure also the provision of dental, ophthalmic and surgical appliances, nursing and midwifery and rehabilitation after accidents. Whether or not payment towards the cost of the health service is included in the social insurance contribution, the service itself should (1) be organized, not by the Ministry concerned with social insurance, but by Departments responsible for the health of the people and for positive and preventive as well as curative measures; (2) be provided where needed without contribution conditions in any individual case."

Restoration of a sick person to health is a duty of the State and

and the sick person, prior to any other consideration. The assumption made here is in accord with the definition of the objects of medical service as proposed in the Draft Interim Report of the Medical Planning Commission of the British Medical Associations "(1) to provide a system of medical service directed towards the achievement of positive health, of the prevention of disease, and the relief of sickness; (2) to render available to every individual all necessary medical services, both general and specialist, and both domiciliary and institutional."

Beveridge feels that the problems of organization of medical service do not fall within his realm. For the same reason he avoids a discussion of many important questions, such as free choice of doctor, group vs individual practice, the place of voluntary and public hospitals, and the status of medical education. It is assumed that upon the institution of the total program the administration of medical treatment shall be lifted out of social insurance and become a part of a comprehensive health service. Accepting this as possible, the major consideration left is that of the method of financial manipulation.

This question of finance is considered under the following heading: (1) separate domiciliary treatment; (2) institutional treatment; (3) special services like dental and opthalmic treatment; (4) subsidiary services such as supply of medical or surgical appliances, nursing and convalescent homes. Under these various headings, the same general trend of thought persists; That the state shall make available all such services by paying part of the expense through taxes and part by requiring every individual to carry insurance of the prepayment type. This is to bring the individual cost down to a level that can be adequately

cared for in insurance payments by every income group. Hereby, there is retained a feeling that the individual is paying for his own care, but in such a way that it is not a financial burden. Thus the responsibility is shared by the individual and the state.

Post-medical treatment is regarded as a continuous process by which disabled persons should be transferred from the state of being incapable under full medical care to the state of being producers and earners. It is sufficient to put forward three general propositions: —from Beveridge, "(1) that rehabilitation must be continued from the medical through the post-medical stage till the maximum of earning capacity is restored and that a service for this purpose should be available for all disabled persons who can profit by it irrespective of the cause of their disability. (2) That cash allowances to persons receiving rehabilitation service should be the same as training benefit, including removal and lodging allowances where required. (3) That the contributions paid by insured persons should, as in the case of medical treatment, qualify them for rehabilitation service without further payment."

It is evident that much of the medical planning is being left to the British Medical Association, whose plan we shall present next.

FUTURE FOREIGN PLANS
BRITISH MEDICAL ASSOCIATION MEDICAL PLAN RESEARCH
INTERIM REPORT

The British Medical Association's Medical Planning Commission has submitted its recommendations on social service and medical practice for the future in the form of an Interim Report, This task was undertaken by Medical Planning Research, an organization of 400 anonymous British physicians, most of them under forty-five years of age. They include doctors now in the armed services, doctors in civilian practice, conservatives, middle-of-the-roaders and liberals. Thus we have a report combining the views of a diverse group of men, all interested in the future of medicine which is their own life work.
All quotations are from the original Interim Report, unless otherwise designated.

Drafts of plans were received from over 200 members and these have been edited by small editorial groups and boiled down to the present form. It is intended to be, not a plan for action, but a basis of discussion. The final report will not be drafted until sufficient time for criticism has elapsed, that being at least six months after the initial reports have been circulated.

Guiding Principles: There are two guiding principles to which the members are pledged. First, they agree to proceed by scientific methods. They will collect all possible evidence, submit opinions based on evidence and be ready to admit error, whenever shown by the evidence. Secondly, the plans submitted are to stress the importance of providing

the maximum benefit to the maximum number of patients.

In general the report will be divided into two parts. The first part is to be a broad general outline of proposals for the future of medicine. In the second part, the details of various problems are to be discussed and where possible fitted into the broad picture.

Problems of Medical Planning: It is recognized that there are two groups of problems connected with medical planning. First, medical organization is largely determined by the social pattern of life in which it exists. Contrasting, for example are large communities and small communities which support different types of medical systems. Therefore, any planning for future medical practice must consider the probable social pattern in post-war society and how it will affect medicine. The second group of problems connected with medical planning are those dealing with enviornmental surroundings of the people receiving the medical care. Actually the first group of problems are concerned with what is likely to happen, and the effect on medicine; while the second group of problems concerns that which ought to happen if maximum health, both mental and physical, is to be obtained.

General Problems:

Population: The planning research presents the veidence indicating the changing of the population to an older average age group. Causes of this change are essentially the same ones presented in the Beveridge Report.

In order to meet this problem the following proposals are listed:

(1) "After the war a long-term planned population policy is

needed."

(2) "The main point of such a policy must be to make children an economic asset rather than a liability to all social classes of the population. The best ways of carrying this out appear to be:

(a) A universal system of adequate family allowances for all non-wage earning children.

(b) A universal system of free education, with equal opportunities for all children, and planned vocational training."

(3) "It is only slightly less important to make children a social asset to all classes of the population. This calls for:

(a) A planned housing policy, so that homes and their surroundings may be suitable for the happy and healthy growth of families of 3 or more children.

(b) The provision of nursery schools so that mothers who wish to carry on premarital occupations may do so.

(c) An educational campaign throughout the country to popularize families of 3 or more children. It is useless to carry out such a campaign, however, unless all the material factors working against large families have first been dealt with."

(4) "Having taken steps to encourage fertility it is essential to study the results. To undertake such studies, it is suggested that Demographic Research Department should be set up as a part of a national Social Research Council, analogous to the Medical Research Council. The results of such studies should be published."

(5) "While every economic and social encouragement should be given

to those who want children, the means of avoiding children should also be available to all."

(6) "On the subject of aompulsory sterilization either of mentally defective adolescents on discharge from institutions for children, or of recovered psychotics on discharge from mental hospitals, we express no final opinion. Until more is known of the carriage of defective genes by normal people, and of talent-conveying genes by abnormal people, we consider that it is wiser not to rush in where experts fear to tread."

Productive Capacity as related to Social-Economic Future:

An opinion of experts has shown, and the experience in production during this war affirms, that productive capacity is not limited by financial barriers. On the contrary the only limiting factors are physical and mental labours combined with the amounts of raw material and machinery available, and the power to cooperate in their use. More and more people consider that controls and national planning have come to stay. With that in mind, it is recommended that post-war production be planned nationally, to meet first of all the needs of the people and only then, to supply luxuries. The necessities include physical and mental, and as stated in the Report the physical necessities are: "(1) Nutritious food. (2) Adequate supplies of heat, light, portable water, sewage disposal arrangements and fresh air. (3) Prevention and restorative health services. (4) Clothing necessities. (5) Housing, furniture and hardware."

Mental necessities which are equally important as physicial

necessities and which must be included are: "(1) Adequate education. Free education for all till 18, with the last 4 years increasingly vocational, should be combined with free university or technical training for those who can profit most from it. (2) Adequate occupation. (3) Adequate recreation."

Poverty, its importance in Health Planning: Here the discussion follows the well known and all too true parallel of poverty and disease and the vicious circle they create. The medical planners stress the mental strain of poverty and its resultant effect, not only on the wage-earner but on his whole family. The causes are replicas of those in the Beveridge Report and do not bear repetition.

The propositions dealing with abolition of poverty are listed; "(1) There must be a national minimum wage for both sexes which will enable its recipients to purchase all the basic needs for physical health. (2) To this must be added a wife's allowance where the wife is working domestically. (3) Family allowances for children must be introduced. (4) Unemployment benefit, sickness benefit and widows' pensions must be raised to the national minimum wage level. (5) Old-age pensions must be raised." Here a wise recommendation restricts the amount of the raise, causing it to be below the minimum wage for adults. "(6) In case of all payments above, there must be no means test." In this it means that all members of the community shall contribute and shall have similar rights. "(7) A comprehensive system for the removal of poverty will only work in a community with a high level of production." This provision relates to the problem of those

members of society who refuse to work, It is suggested that such persons be dealt with by worker's committees. Also the neuropath or psychopath who exploits the system must be examined and vouched for by the doctor to give evidence of need before the committee of fellow workers.

Purchasing Power: It is recognised that medical purchasing power is dependent on the distribution of national purchasing power. Therefore, the higher income groups with greater purchasing power receive slightly better medical care. The Robin Hood system of sliding scale fees is workable as long as the doctor gives the same care to all, no matter the amount of the fee and as long as the higher income group is financially able to stand the extra tariff. All this is closely related to productive capacity which is the mirror image of purchasing power and to poverty which is the result of breakdown of one or both of the other factors. Medical planning must of necessity consider these factors. And the future medical practice must be a flexible system, capable of providing the whole community with everything medical it needs. The best must be available for all but the wealthy may still pay more for it.

Distribution of Population and Reconstruction of Town and Countryside: The essence of this part of the Report is that the state should take over all ownership of land and buildings, or at the least take over control of them and supervise all future planning. Then all future construction of industry, etc. will be along hygenic lines.

Paying For the Plan: Present methods of paying for medical

services include the following: (1) Direct payment of fees to doctors, hospitals and allied services. (2) National Health Insurance. (3) Private Insurance plans. (4) National taxation, direct and indirect. (5) Charitable contributions.

The member of the commission set up the following criteria to govern the future payment:

"(1) Members of the public should have the feeling that they are themselves paying for the services they receive; and they should have a measure of freedom in choosing who shall give them these services."

"(2) Doctors should retain, as far as possible, the feeling of dependence on their own efforts, and of independence in their relationship with the state."

"(3) All classes should be able to pay for services when they are well, and should be freed from the burden of payment during and after illness."

"(4) Payments made during times of health should cover all services needed at any time."

"(5) There should be no question of persons wishing to pay private fees at the time of illness receiving preferential treatment over patients being treated on an insurance basis."

"(6) At the same time, some people in the upper income groups do wish to continue private contract for medical treatment. It should be possible for such people to put out of a part of any national

insurance payments, and so cease to be entitled to medical benefits."

"(7) The amount of insurance payments should be based on capacity to pay - i.e., on some income assessment."

"(8) The burden of health services should be removed from the rates."

"(9) The nature of the payment should be as simple and as comprehensive as possible.

"(10) There should be no levy on employers or on any other isolated section of the community."

To fulfill the above requirements, it is proposed that every wage-earner, salary earner, or person in receipt of any form of earned or unearned income should pay a compulsory, single social security insurance premium. These premiums should be graded according to incomes. In return for such a premium every contributor shall be entitled to; (1) complete treatment for all forms of sickness. This is to include rehabilitation and necessary training to return the person to that condition in which he can earn a living, either in his old occupation or a new one. The contributor should be free to choose his own home doctor. (2) Specific prophylactic measures provided to aid maintainence of positive health. (3) Adequate cash sickness benefits for the contributor until he or she returns to work. (4) Cash unemployment benefit, on the same scale as sickness benefit. (5) Adequate old age pension and widows' pension on the same scale. (6) Burial allowances, (7) Adequate family allowances. As stated previously, there shall be

no means test, because it tends to discourage thrift. Instead, it is believed that a need test would be more trustworthy in application.

Figures by the Ministry of Labour show that the British families in 1937-38 were paying about 7.35 per cent of their total expenditure for medical care, unemployment insurance, pension insurance and the like. The estimate in this program is that 10 per cent of the total expenditure for a family will more than carry the individual load in the providing complete social insurance. This ten per cent expenditure would be paying for thirty per cent of the total cost of the National Social Security program. The Crown or Central government in 1938-39 was paying for 65.5 per cent of the bill for all social services, including medical services, the money being derived from taxes, both direct and indirect. If this percentage were raised 4.5 per cent to 70 per cent, the future program would be adequately financed. An alternate suggestion is that the 10 per cent paid by the individual be included in the income tax, this being a supposedly more painless way of paying the bill. In either case, we see a plan which closely parallels that of the Beveridge Report, in which State contribution lowers the cost level for social services to the point that each individual can participate to the full extent by contributing only 10 per cent of his earnings, no matter what his income.

Administration:

Under the sub-head of "Principles of Administration" there is a thorough coverage of the various methods by which large organizations can be controlled. Some of the mutually opposed forces upon which the

balance of efficiency depend are: "(1) The technician versus the administrater. (2) Parallellism versus hierarchy. (3) The individual versus the committee. (4) The centre versus the periphery. (5) Uniformity versus diversity."

Each of these has been studied and later in the report we find that the benefits of some of these forces are applied to the administrative plan.

Likewise there is a long discourse on the types of committees and their role as opposed to the individual in administration. "The following types of committees commonly occur: (1) Legislative, (2) Directing (3) Executive or administrating, (4) Coordinating, (5) Advisory, (6) Judicial, (7) Research or investigating." "In practice, committees often perform more than one of these functions." Here again the practical application of such committees will be of value in administration.

Having fully adjudged the merits of general administrative policies and committee organization, the participation of the individual in the picture is presented. The values of certain methods of appointments, methods of remmuneration, conditions of tenure, principles of advancement and possibilities of change are weighed. From all of these are derived the general suggestions as to an organizational plan which will be presented in brief.

Application of Previous Discussion to a General Plan: This application may be explained best by referring to chart # II. Certain explanatory remarks are necessary and will be given here. In order to appreciate the scope of the plan it is advisable to compare this chart with chart # I of present system.

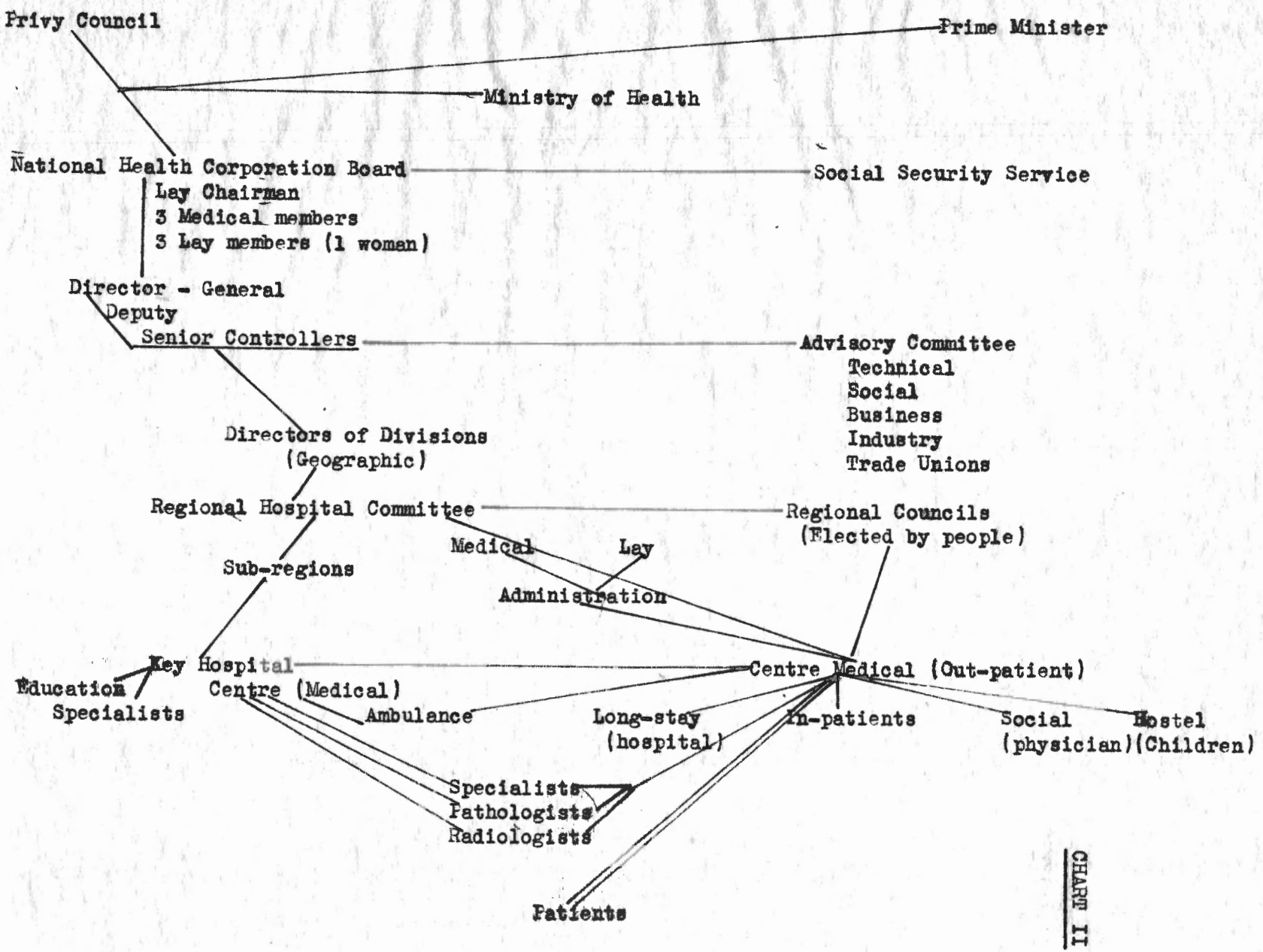

Privy Council
Prime Minister
Ministry of Health
National Health Corporation Board
Social Security Service
Lay Chairman
3 Medical members
3 Lay members (1 woman)
Director - General
Deputy
Senior Controllers
Advisory Committee
Technical
Social
Business
Industry
Trade Unions
Directors of Divisions
(Geographic)
Regional Hospital Committee
Regional Councils
(Elected by people)
Medical
Lay
Administration
Sub-regions
Key Hospital
Centre (Medical)
Education
Specialists
Ambulance
Centre Medical (Out-patient)
Long-stay
(hospital)
In-patients
Social
(physician)
Hostel
(Children)
Specialists
Pathologists
Radiologists
Patients

CHART II

The health organization, to be known as the National Health Corporation, shall be placed under the Ministry of Health along with a parallel set-up of the social services. However, the National Health Coroporation shall be controlled by a group of seven members including a lay chairman, three medical members and three lay members (one of whom shall be a woman). This group will be appointed by the Privy Council, subject to the recommendation of both the Prime Minister and Ministry of Health and shall hold office for from 3 to 7 years with a limit of one reelection. This corporation shall be charged with the spending of National Health funds, which are to be obtained in a block grant from the Social Security Fund, previously described. The Director-General, ex-officio secretary of the Board, shall be the principal executive officer. He should be a medical practitioner and should have a deputy. Senior officers in charge of large sections shall be called controllers with the same salary as the Director-General. Beneath the Senior Controllers shall be the Directors of Divisions. These men are peripheral directors in charge of geographical rather than functional divisions. Coordinating the parts of a region shall be the duty of Regional Hospital Committees, composed of representatives of all hospital-owning bodies or authorities. The regions proposed are administrative and not medical, leaving the patient free to choose doctors or hospitals outside the region, if he wishes. Subregional divisions shall be placed so that the medical needs of the population are adequately provided for. The actual ownership of the hospitals and facilities can be either

state or private, the only requirement being that it function within the fabric of the Corporation.

Up to this point, the description has been of the purely administrative organization. Now, it is proper to consider the set-up for the actual practice of medicine. The Medical Centre with parallel medical and lay administration is the nucleus of the distribution of medical care. Such centres are to be located so as to serve adequately the geographic and population needs. They may or may not have a key hospital attached to them, but attached to each medical centre should be the local health centre.

The key hospital will be a teaching hospital associated with a university and in addition perhaps having specialized units for the care of certain diseases, especially those in which research work is being carried on. Actually the medical centre will be a large polyclinic through which are sent all patients who are beyond the scope of the home doctor. As noted on the chart, the centre has these various subdivisions:

(1) Out-patient Department

(2) In-patient service

(a) Fever diseases, (b) Maternity (c) Medical cases (d) Surgical (e) Pediatrics .

(3) Pathological and Radiological Department

(4) Ambulance service

(5) Social physician, to deal with social problems connected with medical problems. These men should have special training.

(6) Long-stay or chronic hospitals in association with it. (i.e.)

(a) Tuberculosis, (b) Mental cases, (c) Orthopedic rehabilitations

(7) Hostel for care of children under 15 whose mothers need hospitalization.

The Doctor and his work: A classification of doctors and their work is suggested as the following:

"(1) The home doctor - a family doctor, the general practitioner.

(2) The specialist or consultant.

(3) The social doctor - environmental doctor or medical doctor of health."

In addition the above groups perform other important functions, namely:

"(1) Teaching - technical for medical students, student nurses, and other technicians and, to a small extent, popular, for members of the public.

(2) Research.

(3) Administration."

The Home Doctor: The Home Doctor brings the position of the general practitioner back to the importance it should have. In this plan he is the sorter of patients, the true family physician especially trained for his job.

From the patients point of view, he must perform the following functions:

"(1) He must be the doctor of the patient's choice."

"(2) He must examine and advise the patient at a point reasonably near the patient's home at a mutually convenient time, whenever the

patient wishes it."

(3) He must give the same standards of advice and skill to all his patients, regardless of their class, social status, or income."

(4) When he has reached the limit of his skill, he must not conceal the fact from himself or the patient. He must then arrange for the patient to see an appropriately skilled specialist, and must cooperate with this specialist in carrying out treatment when the patient leaves the specialist's hands. Furthermore he must arrange for a specialist opinion at the patient's request, even when he himself considers this unnecessary."

"(5) When it is necessary, he must arrange for the patient to receive appropriate institutional treatment."

As a specialist in his own field the Home Doctor must be an expert in:

"(1) General bedside diagnosis, especially medical and surgical emergencies."

"(2) General home treatment (including, in remote areas, dispening, but excluding biochemical medicine such as the stablilzation of diabetes, and specialized treatment, such as veneral disease)."

"(3) Simple clinical pathology."

"(4) The diagnosis and home treatment of specific fevers, skin diseases, diseases of the eyes, ears, nose and throat, children's diseases, gynacological diseases, and minor psychiatric illnesses."

"(5) After-treatment of all institutionally treated illness."

"(6)Child welfare."

"(7) Ante and post-natal care, and possibly midwifery.

"(8) Minor surgery and medical first-aid in surgical emergency (excluding anything but the first-aid treatment of fractures)."

"(9) Forensic medicine as it affects general practice."

Doctors point of view:

In order to function to the height of his capacity the Doctor must be working under the best conditions. The conditions considered essential are as follows:

"(1) He must not have to "buy his way in" to a practice. His early years in practice must not be crippled by the heavy debt which purchase so often involves."

"(2) He must be a free man - free to throw up his practice if he wishes to do so; free to refuse to accept a patient (though having once accepted, he must carry out his obligations); free to increase his practice by his own efforts up to a point where it is generally judged that efficiency is reduced; and free from undue bureaucratic interference, whether medical or lay. If he fails to carry out his statutory obligations, he must be subject to statutory discipline, and not the inroads of officialdom. Unless our doctors are free men, they will lack the sense of responsibility on which the doctor-patient relationship rests."

"(3) His remumeration must be adequate, from the outset of his career, and must bear a relation to the amount of work he does."

"(4) He must be adequately housed, and adequately equipped for his work."

"(5) By arrangement with his colleqgues, he must have regular and adequate off-duty times. He must have regular holidays."

"(6) Once every 5 years at least he must have a refresher course specially planned for his needs."

"(7) Within his general field, he must have opportunities for acquiring and utilizing special skills."

"(8) He must keep in contact with his colleqgues, general and specialist, and for this there must be a physical focus. His primary focus will, in fact, be the health centre; his specialist focus will be his local polyclinic and hospital."

"(9) He must be adequately insured against sickness and provided for in old age."

The Specialist and Hospital Services: Complimentary to the Home Doctor and his work are all functions of the hospital services and associated specialists. Such a plan must require of the hospitals the following facilities:

"(1) Consultation in clinics reasonably near the patient's homes, and, when necessary, consultation in the patient's own homes."

"(2) In-patient investigation and treatment."

"(3) Out-patient treatment for conditions beyond the scope of the Home Doctor."

"(4) Special treatment for long lasting and chronic illness."

"(5) Rehabilitation (positive convalescence)."

"(6) Training of doctors, nurses, and ancillary health workers."

"(7) Research."

The Specialist will serve as a consultant and as doctor to those cases referred to him in his own field. Patients shall have the right to choose their own consultants or specialists, if such are necessary. As is the tendency now, the specialist will carry on most of his work as a member of the hospital and medical centre staff.

The Medical Staff: The principles governing the medical staff would be about as follows:

(1) All appointments should be advertised.

(2) The clinical and administrative ladders should be separate.

(3) No member of the senior staff should be confined to out-patient work and none should be free from it.

(4) The conditions of appointment, pay, promotion, etc., should be the same in all hospitals whether key, long stay, special or medical centres.

(5) Both part-time and full-time appointments should be available.

(6) There should be at least one member of the whole-time staff for each major subject in the teaching key hospitals who is a university professor.

(7) Adequate provision should be made for holidays, pensions or retirement and sickness.

(8) Movement of personnel both within and between hospitals should be encouraged, as should travel at home and abroad, in order to gain experience.

(9) A uniform set up for handling the junior appointments and advancements should prevail.

It is easy to see that a combination of the Beveridge Report and the Medical Planning Commission Interium Report provide a well organized plan for study. Whether such a system will work or not remains to be seen.

FOREIGN PLAN: CANADA

"A general plan for health insurance was presented for study and consideration to the House of Commons Committee on Social Security by the Honourable Ian Mackenzie, Minister of Pensions and National Health, on March 16th." (Canadian Journal of Public Health; July '43) This plan covers only the problem of medical care, but indicates that complete medical care includes, also, nursing services, hospitalization, medicines and drugs, and dental care.

Due to some provisions in the Constitution of Canada, it is not possible to institute a comprehensive Dominion-wide national health insurance act. Therefore, it is suggested that the health program be administered on a Provincial basis with assistance financially from the Dominion.

A draft bill of a possible plan for the Provinces to be guided by is summarized:

Coverage:

Such a plan is to include all persons resident in Canada. There will be no compulsion placed on the Provinces in this respect, provided that all indigents are included in the plan.

Health Insurance Fund:

A health insurance fund will be created from money contributed by insured persons, employers, the provincial government and the Dominion government. The personal contributions is estimated at $26 per person. Each person will pay the entire cost if it does not exceed three per cent of his income. If he is a wage-earner, his employer

will pay the difference, if not, the province will do so. Such combined contributions will be supplemented by a Dominion grant.

Registration:

When the plan is adopted, all residents will register and select a doctor from the approved list. The physicians' pay will be decided by the Provincial Health Insurance Commission.

Benefits:

a. Medical service include those of a general practitioner, consultant, surgeon, obstetrician, nurse and hospitalization.

b. Dental care will be restricted by the lack of sufficient dentists. First consideration will be care of children up to the age of sixteen.

c. Pharmaceutical

d. Hospital includes general ward unless necessary to have private room or the insured pays the difference.

e. Nursing benefit will be limited to visiting nurse, unless bedside nursing is essential.

Administrations:

The Administration will be provided for by the Health Insurance Commission in each of the provinces. This commission will be composed of a chairman who shall be a doctor of medicine, the Deputy Minister of Health of the province (ex-officio) and such other persons as shall be deemed necessary. Consultation will be held with representatives of professional groups, laborer, agriculture, industrial and the like groups.

Grants:

The Dominion will make separate agreements with each province to assist them with grants of money to provide various additional health services. The eight proposed grants are:

a. Health insurance; b. Tuberculosis; c. Mental diseases; d. General public health; e. Venereal disease; f. Professional training for professional men to get training for degrees in Public Health; g. Investigational; and h. Physical fittness. (prophylactic).

Costs:

There is nothing here of value, except that they believe it will be easy to pay for the program proposed in the previously described Health Insurance Fund.

UNITED STATES PLANS: MURRY-WAGNER 1161

On June 5, 1943, a plan was offered Congress as a basis for legislative study and consideration. This plan proposes to create a Unified National Social Security Insurance System. The Senate version was introduced by Senators Wagner of New York and Murray of Montana as (S 1161) and Representative Dingell of Michigan introduced it to the House of Representatives as H. R. 2861.

General Purpose: The bill advocates a broadening of the present Social Security plan so that it will include the following:

1. a system of public employment offices,
2. increased old age and survivors insurance benefits,
3. temporary and permanent disability insurance,
4. protection to individuals in the Military Services,
5. increased unemployment insurance benefits,
6. federalized unemployment system,
7. maternity benefits,
8. medical and hospitalization insurance benefits,
9. broadening of the basis of existing social security program so as to include persons now excluded; such as: farm workers, domestic workers, independent farmers, employees of non-profit organizations, the professions, and other self-employed individuals.
10. unified public assistance program.

How Financed: This new inclusive system is to be financed by taxation. Through the following taxes there will be created a "Federal Social Insurance Trust Fund". There will be 6 per cent employee and

a 6 per cent employer tax on all wages and salaries up to $3,000 per year. The self-employed will pay 7 per cent up to $3,000 a year.

The employees of Federal, state and municipal groups (under certain conditions) will pay a tax of 3½ per cent. The estimated total annual revenue is around $12,000,000,000. (National Physicians Committee for Extension of Medical Service - based on United States Treasury estimates.)

Medical Provisions (Brief): An analysis of the medical clauses will give insight to the purpose and possibilities of the proposed measure.

Scope: Every insured individual and dependent shall be entitled to receive the following: 1. General medical benefits which according to the provisions, include all the medical services which can be provided by a general practitioner. This includes preventive, diagnostic and therapeutic treatment and care, plus periodic physical examinations; 2. Special medical benefits include all the services which can be given by a legally qualified and recognized specialist; 3. Laboratory benefits including necessary laboratory or related services, any care not provided under medical and hospital benefits; 4. Hospitalization benefit includes the use of all facilities least expensive but compatible with the proper care of the patient.
The suggested limitations which may be changed by the Surgeon General, are allowances of $3.00 to $6.00 per day for not more than 30 days; $1.50 to $4.00 per day after 30 days and $1.50 to $3.00 for patients in chronic hospitals.

The Doctor: Any legally qualified medical doctor may participate. The Surgeon General will obtain and publish the list of names of all doctors desiring to practice under the plan.

Patients will choose their own doctor and can change doctors in accordance with the rules and regulations prescribed by the Surgeon General.

A maximum limit to the number of patients that a doctor may have on his "panel" will be determined by the staff of the Surgeon General. Certain "relevant factors" will enter into local problems as to patient-doctor relationship. The services of a specialist will be available to the patients only on the recommendation of the general practitioner on the case. Specialists and their qualifications shall be determined by the Surgeon General.

Doctor Payment: Four methods of reembursing the doctors are set forth:

1. Payment on the basis of fees for services rendered, according to the fee schedule set up by the Surgeon General.

2. By a per-capita basis, the amount being determined by the number of patients on the practitioners list.

3. On a salary basis, whether it is whole or part time.

4. A combination of any or all of the above methods.

Hospitals: It will be necessary for the Surgeon General to approve all hospitals desiring to participate in the program. This approval will depend on the consideration of the type of services to be rendered. The plan will provide hospitalization for each individual entitled to benefits up to 30 days per year. This may be incresed

to 90 days if funds are available.

Finance: A block fund designated as the "medical care and hospital account" will be transfered from the "Federal Social Insurance Trust Fund."

Education: One per-cent of the total amount collected under the Social Security Insurance Plan will be set aside for an education. This will take the form of grants-in-aid to be divided and controlled by the Surgeon General. Three separate fields for grants-in-aids are recommended: a. Research; b. Graduate work; c. Under-graduate work.

Supplemental Services: The Surgeon General and Social Security Board must determine some method of providing adequate nursing, dental care and other benefits as are commensurate with this plan.

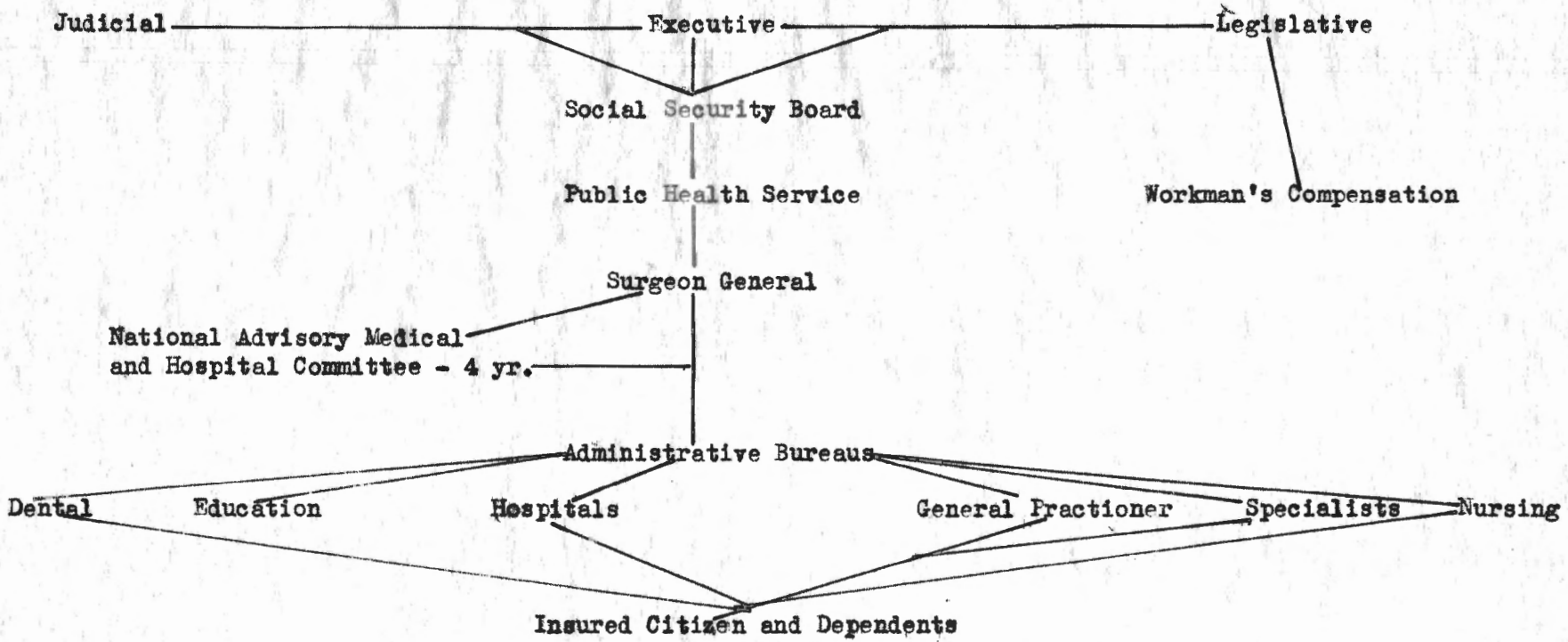
Administration: By study of chart # III the simplicity of theoretical administration is obvious. The Surgeon General of Public Health will take the necessary steps to put the plan in operation and thence-forth shall control the program. An Advisory Countil is to be appointed by the Surgeon General from a list submitted by all organizations concerned. There will be sixteen members, appointed for four years with staggered terms of office.

The Surgeon General will be advised by the "Council" as to -

1. Professional standards for general and special medical benefits,

2. Designation of specialists,

3. Methods and arrangements for stimulating and encouraging high standards in all branches of medicine and allied services,



The Wagner - Murray Senate Bill No. 1161

CHART III

4. Quality and adequacy of service being furnished by the profession,

5. Methods for paying for medical and hospital services,

6. Grants-in-aid for education,

7. Establishment of special boards, commission, committees, etc., as deemed necessary.

Briefly, the Surgeon General will have complete control over all phases of medical practice in our country.

UNITED STATES PLANS: COOPERATIVE MEDICINE

There are a number of various definitions of cooperative medicine, and they tend to cause much confusion when discussed. Therefore, the plan of cooperative medicine as suggested by V. I. Tereshtenko may be defined as "the application of cooperative principles to voluntary health insurance."

Principles: The most commonly accepted principles applied to cooperative medicine are the so-called "Rochdale principles." These principles are:

a. Open membership, without restriction as to sex, religion, etc.

b. Democratic control, which expresses itself in rule 'one vote per member' (irrespective of the number of shares owned) and 'no proxy voting.'

c. Distribution of surpluses resulting from the economic activity of the organization in proportion to the member's patronage, not in proportion to his holdings in shares or capital.

d. Religious and political neutrality.

Organization: The various contributors to the development of the cooperative medicine plan recognize that no one plan of organization will fit all circumstances, local conditions, or composition of membership. However, there are two characteristics which must be considered indispensable. (Tereshtenko)

"1. Consumer's cooperative control. This is typified by the second of the "Rochdale principles." In addition such control should not interfere with the work of the medical staff and their personal practice of medicine."

"2. Periodic payments. Such payments should be in advance, usually on the monthly basis. The amount of payment depends variously upon local conditions, the scope of service rendered by the organization, and the number of its members."

Next, it is considered that there are two other characteristics which, although not indispensible, are advisable.

1. Group Medical practice. This implies only to the agreement of a number of physicians to pool their practice by working together, sharing office equipment, patients, case histories and compensation recieved.

2. Preventative Medicine.

Actually there are many examples of these principles in operation in the United States at present. The highly publized Kaiser Plan is just a variation of this system. (Science Digest; November, '43)

UNITED STATES PLANS: V - PLAN

Picking a catchy title, the Medical Administration Service has submitted a plan called the V-Plan. The V does not pertain to the present "V for Victory", but to the "Voluntary hospital", which is the basis of the proposal.

Principles: Development of the V-plan calls for the coodinated use of a number of proceedures, which are, briefly: First, the application of the insurance principle to medical care. In a community wide organization, each member contributes a predetermined amount of money and all recieve basic benefits. Second, preventive medicine as practiced by a combination of doctors, health centers and informed partients. Thirs, group practice. This means the utilization of a team of physicians, each treating the patient whose illness falls in his particular field. Fourth, using non-medical personnel to do work that does not have to be done by a doctor himself. Fifth, education of the public. At present, this plan calls for putting these ideas into operation within existing voluntary hospitals and later, if the scheme is successful, an extension into other existing proprietary and tax-maintained hospitals.

Basis of Plan: The Voluntary hospitals may be considered to be those which are usually non-profit corporations, administered by boards of public spirited citizens. They usually serve needy patients gratis and are supported by payments from private patients and by charitable contributions. Quite a number are under church auspices.

As stated, the plan will be based on the local voluntary hospital.

The success of the proposal depends on the coordination of the local hospital with the members of the community.

Organization: The organization may vary with each locality, but it is recommended that a community health association be formed to which all members in the community would belong, on a business basis.

Finances: A scale of rates should be set up by the community health association to be supplemented by taxes and where possible by employer contributions. The community will pay the dues of those unable to pay. Payment should be arranged on monthly basis, either payroll deduction or direct collection.

Health Service Center: A center, whereby a concentration of medical staff offices in or near the voluntary hospital is brought about, will facilitate the handling of patients and their problems. All services should be available to all the members according to need.

Staff Organization: The staff will be divided into three arbitary groups.

1. In-hospital attending physicians
2. Out-patient department attending patients
3. Auxillary physician, attending patients at home or in their offices.

In the first two catagories, the staff would be theoretically a closed one with doctors belonging to both groups if they wish. Auxiliary doctors would refer patients to the clinic when necessary and could work in the hospital of clinic under supervision of the members of the first two groups.

Doctor Compensation: A full-time salary based on scientific acumen and medical skill is the method suggested for compensation. There is no mention as to who shall determine such standards.

UNITED STATES PLANS: NATIONAL HEALTH PROGRAM

This is a resume' of the main points presented in the summary of the Program recommended by the Technical Committee on Medical Care to the Inter-departmental Committee to coordinate health and welfare activities and presented to the President February 14, 1928.

A great deal has been written and said about the proceedings at the National Health Conference held in 1938. What is more, a great deal was said and written at that conference, and, after reading about it, it seems wise to present only this brief resume' of recommendations. Anyone desiring entertainment, but not accurate information will enjoy Rortys book "American Medicine Mobilizes".

Present Deficiencies: According to the committee's study, medical and health service deficiencies fall into four braod catagories:

"a. Preventive health services for the nation as a whole are grossly insufficient."

"b. Hospital and other institutional facilities are inadequate in many communities, especially in rural areas, and financial support for hospital care and for professional services in hospitals is both insufficient and precarious, especially for services to people who cannot pay the costs of the care they need."

"c. One third of the population, including persons with or without

income, is receiving inadequate or no medical service."

"d. And even larger fraction of the population suffers from economic burdens created by illness." (National Health Program-Summary)

Recommendations: The committee makes five general recommendations which are to be put into effect over a period of ten years. It contemplates a gradual well-planned expansion in the line with general proposals.

I. Expansion of Public Health and Maternal and Child Health Services.

a. Public health services expansion along both state and national lines, with exphasis on prevention of disease.

b. Maternal and Child Health Service "to make available to mothers and children of all income groups and in all parts of the United States minimum medical services essential for the reduction of our needlessly high maternal mortality rates and death rates among newborn infants, and for the prevention in childhood of diseases and conditions leading to serious disabilities in later years." (National Health Program - Summary)

II. Expansion of Hospital Facilities.

a. General and special hospitals according to need, especially low-cost hospital beds.

b. Tuberculosis sanatoria

c. Mental institutions

d. Health and diagnostic centers in areas inaccessible to hospitals. The expansion of facilities means more than physical equipment, it means improvement and increase of

personnel with adequate remuneration so that better care will be available to all.

III. Medical Care for the Medically Needy: Such care to be improved and maintained by local state or federal governments, jointly or singly.

IV. A General Program of Medical Care: It is recommended that consideration be given to a comprehensive program to increase and improve medical services for the entire population. This should fill in the gaps left after the institution of Recommendations I and III.

Finance: Financing of such a vast program could be executed by one of two ways.

a. General taxation of special tax assessments.

b. Specific insurance contributions from the potential beneficiaries of an insurance system.

Organization: A program such as this should preserve a high degree of flexibility in order to allow for individual initiative and for geographical and economic variation, medical facilities and governmental organization.

V. Insurance against loss of wages furing sickness.

PART III

A BRIEF DISCUSSION OF NEED

NEED

Introduction to Need: The first part of this paper has described some of the more important systems which endeavor to bring medical care within easy access of all patients. In the second part, a number of the most comprehensive plans for medical care in the future were presented. In all cases the analysis was made after extensive study of the plans and systems. As near as possible the author has refrained from comment which might throw either favorable or unfavorable light on any one scheme. It was necessary in most cases to balance the opinions of both advocates and opponents in order to give an accurate picture.

This portion of the paper deals with the need for a change from the present system of medical practice in the United States. Here we shall present the outstanding reasons for considering a change of medical policy.

There are a number of objections to the detailed presentation of the 'pros and cons' of the needs. The first being that it would require another thesis to cover the field of Need. Secondly, the figures showing either need or no need are gathered by two opposing types of minds. The sociologist bases his argument on a so-called cross-section group and by inductive reasoning arrives at a conclusion. He believes that the whole country is represented by his conclusions. On the other hand the medical man usually relies on a scientific approach, requiring complete surveys of every possible item and because of his deductive mind will not believe the picture to be accurate without every

detail. Consequently their figures and facts are in constant disagreement.

Any honest medical practitioner will admit that the present system does not extend the maximum care to the greatest possible number of people. This part of the writing will be based on theory and will be to a great extent contradicted by the practicability discussion later on.

The conclusions presented here and in the rest of the paper will be those of the author and are based on the reading of many articles and editorials on the subjects. References to the reading will be few, but a special bibliography will list those articles which have influenced the expressed opinion.

Progress: Medicine has made great strides in the last half of a century. In fact the progress of scientific medicine has far outdistanced its application. Although we have improved our methods for the cure and eradication of many pathological processes, we have failed to make them available to all of the population.

The empirical treatment of disease is rapidly being abandoned by the trained men of our profession. Accurate diagnosis with subsequent specific treatment is the forte' of modern medicine. A patient who comes in early with his complaint and who is handled by a well-trained, concientious doctor has a good chance of being cured. The men in the specialities are capable of giving the finest care the world has even known. Still a great number of people suffer and even die needlessly. Part of this cause is due to lack of sufficient highly trained men, but it is only a small part. The real difficulty is economic. As the cost rises the number of people receiving the best care declines.

The rapid improvement of transportation and communication has placed nearly every patient within range of good medical care, provided the patient can afford to accept it. Why isn't the medical care utilized by all? The doctors take care of all the indigent without compensation and give them excellent care. Doesn't that take care of the problem?

The Patient: An analysis of the position of patients in different economic strata will help explain the last two questions. In all but very rare instances, we can consider the urban and rural patients in the same catagory. During the horse and buggy days, the rural patient was a different problem. But as stated before, our modern transportation and communication systems have solved much of that problem.

The indigent patient is well cared for by free clinics and the policy of the doctors to give gratis care where indicated. Also receiving excellent care are the members of the upper middle and well-to-do income groups. But what about the large group inbetween those two extremes? Here is the man with the problem. He is an individualist, paying his own way in the world but on a moderate income. He does not want charity and his pride will not let him accept it even when it would keep him from bankruptcy. When he is sick, he does not call the doctor until absolutely necessary, because of the thought of the cost. Then, if a serious illness befalls him, or a series of such incidents the medical cost often ruins him financially. It is true that many of these people make enough to save money for emergencies, but they just don't do it. This is the lower middle income group.

What does this large group need in the way of improvement? They need either a method of paying for medical care while they are well and earning money or medical care furnished by the state and paid for by taxation. The difficulties in solving this will be discussed in Part V.

Hospitals: What is the situation in regard to hospitalization? The same situation pertains here as in the problem of medical care. Indigent and well-to-do patients are quite well provided for, although there is still room for much improvement. The lower middle class is the least well cared for. The tendency to mix chronic and acute cases in all of the various types of hospitals causes a great waste of bed space. And again the unplanned for cost of hospitalization completely upsets the average American household budget. The general concensus of most writers indicates that there are two major problems in hospitalization. First, a necessity for a method of prepayment of the bills by either individual insurance or a state system. The second problem involves the reallocation of much of the present facilities and some additional facilities.

I. Acute Hospital: Elaboration of the last statement will help to clarify it. A certain proportion of present bed space needs to be classified for the use of acute illness, both medical and surgical. This space should be arranged for in well-equipped emergency hospitals and such hospitals must be conveniently located. Admission of all acutely ill patients must be allowed, without consideration of financial status. Much of the financial burden

could be relieved by the suggested prepayment plans. Obviously these early admissions and emergency care will save many more lives.

II. Long-Stay Hospital: Next in the reallocation program is the care of the long-stay patient. Much of the tax money now being used for relief of the middle and lower classes could be used to improve chronic hospital facilities. This would include the attraction of better men to the jobs, the increasing of prestige by better management. It should be possible for good doctors to make a decent living while working with the chronic-patients. More and better nursing is a prime factor here. In the long-stay class we place tuberculosis, mental disease, rheumatic fever patients, orthopedic, special pediatrics and the like problems. This group will also deal with rehabilitation and readjustment of living where necessary. Such work will require special apparatus and specially trained men. Separate hospitals may be necessary for the above entities.

III. Convalescent Hospital: Finally hospitalization must include a new type of hospital, if the program is to be well organized. This is the convalescent home or hospital. Patients are sent here after they are beyond the need for special care, but still need time to build themselves up. The British have found that such hospitals are easy to maintain, reduce the emergency hospital load and cost. What is more important, they seem to facilitate a more rapid complete recovery by the patients.

Incidently we consider obstetrics as an acute condition.

Physicians Need: Does the doctor need any help? That is a very touchy subject. The successful men say no, the moderately successful are too busy to concern themselves, while the rest say yes.

The first defect in the status of the doctor occurs when well trained young physicians and surgeons waste the early part of their career struggling and starving. Some provision for utilization of the finely trained young doctor should be made. Group practice may do this.

Another item is that the sliding scale application of fees often slides a little too far upwards. Many practioners, especially specialists, should realize it. The upper class is still getting "soaked" out of proportion to the amount of care received. This group is very much behind the agitation for socialized medicine. They feel that if medicine were on a state basis, their own exhorbitant contributions would be decreased. This problem calls for some prepayment plan for the middle class, so the doctor does not have to over-charge the rich to make a living.

Within the profession there is one other all important item, the increasing of general standards of practice. This is being partially met by the special boards under the American Medical Association. Gradually these boards are making it possible for only well-trained men to practice in each speciality. This leaves a large gap in medical practice, the realm of the general practitioner.

We need to recognize the need for general practitioners and the need for special training in that type of practice. This can be accomplished by continually raising the medical school standards, increased

requirement for annual post-graduate study and a return of the pestige of the general practitioner. More teaching of social medicine in schools is necessary and a broader educational requirement in liberal arts should be part of medical graduation requirements. The more specialized the training the narrower the concept of life and of other people.

Group practice on a voluntary basis might help. At least a study of local conditions should precede any change in the type of medical care to be advocated. Action can be guided by those findings. Such action will help the young doctor, the general practioner and the patient. The family doctor will still be important, but will be able to recognize his limitations in the practice of specialties and can refer his patients to his colleagues.

PART IV

POLITICAL - SOCIAL ECONOMIC FACTORS

AFFECTING PRACTICALITY OF A COMPREHENSIVE PLAN

POLITICAL-ECONOMIC SOCIAL FACTORS

This is the most important part of the picture, despite the need no matter how great or small and the beautiful theories for bringing about a radical change, the deciding points are beyond the realm of the medical man. The practice of medicine is but one item to be considered in the future of the United States. Therefore, it will pay us to study a number of angles as to the practicality of any one or all of the afore-mentioned theories.

Cost: The estimate of the cost in the Senate bill 1161 (Murray-Wagner) is set at $12,000,000,000 a year for all social security, including medicine. Medicine will take $3,000,000,000 of that amount. It appears that no one is really in a position to know whether such a cost can be handled or not. The present cost of the War and all the ideas concerning the possibilities of there being a limit to National spending and consequently the Nation debt have caused many revisions in economic thinking. Not being in a position to make a positive statement, let us assume that the money can be raised. What then?

A number of varibles may affect the financial budget. The cost is only an estimate and may run much higher. We know from experience that all such estimates are usually low. Then too, what is the cost of political control? That too is inestimateable. No matter what the politicians say, examples are before us all the time showing the great waste involved in bureaucratic government.

Another factor is our post-war condition. It is likely that we shall have our hands full trying to pay the cost of the war and the cost of reconversion to peace time industry. Are we going to be able to add

on more spending? The present administration' broad plans for rehabilitating the rest of the world will help exhaust the National pocket-book, now quite sufficiently in the red. Are there enough chickens for all the kettles?

Variable population: The United States contains a very large variegated population. Our census is many times that of any of the nations who have had even moderate success with state medicine. The best examples being Denmark and Great Britain. We have more separate groups and races. Will any one plan be workable for all?

Geographic: Not only is our population far greater, but, it is scattered over a very large area. The most successful plans are in operation in countries with a small population living in a relatively small area with but slight geographic variations. Can we apply one great plan to both Arizona and Rhode Island? The problems of New York City and Butte, Montana are different. One overall plan will require control over the doctors. What kind of compulsion is to be used to control the medical men and still allow for exercise of individuality which is the backbone of present medical progress.

State vs National Control: One of the strongest under-current issues in politics today is the relative power of the state and national governments. The great medical plan must overcome this problem, which is far from settled. Read the platform of the Republican party. (Time, Oct. 2, '43) If the plan is instituted as a state plan with National subsidation, how will the problem of Interstate medicine be settled? Who will say what state a doctor shall practice in? How can a patient

transfer from one part of the country to another and still recieve care in an emergency.

Group Attitudes:

Labor: The labor organizations fought the idea of social medicine after the last war. However, under the coddling of the present administration labor has come to expect life on a platter. Spokesmen for the unions, especially the C. I. O. have indicated that they favor the trends toward complete social security. The Wagner-Murry Senate bill has the support of the leaders of the Unions. (William Green, Time, Oct. 16, '43) The attitude of the worker as an individual is not known, as is the case on nearly every issue.

Capital: Industry does not favor state control of medicine. The obvious reason is that any tendency toward socialization means more control over industry later on. One of the major post-war issues will be the amount of control to be exercised by the government over industrial enterprise.

Banking is in the position as industry. They fear, and rightly too, the administration's continued perogative in finance control.

One of the real opponents of state socialism is the great life insurance business. Such a change as sponsored by the Senate Bill 1161 would completely ruin the insurance future.

Average Business Man: Here is a real diagnostic problem. No one knows the real position of the average business man. Nevertheless we may make these general statements. (1) He would like a reduction in in the cost of medical care, but would like to handle it as an individual.

(2) He fears and is fighting the centralization of business sponsored by the government. The small business man is fighting for his life against the trend toward socialism.

The returning soldier: A great unknown quanity is the returning soldier. What is in his mind for the future of his country? Well, he is risking his life to preserve some principles which no one is sure of. The average American soldier probably believes that the American way includes at least these items: (1) The right to have a home; (2) The right to work at job of his own choice in competition with his fellow-Americans, (i.e.) individual enterprise. (3) The right to think, speak and write as he sees fit; and (4) Religious freedom. But does he expect to have to pay for a "cradle to the grave" program of paternalism for all? We doubt that.

American Medical Association: So far as this study can see, the American Medical Association is blindly fighting a defensive battle. The present spokesman have been following this proceedure so long that not only is the profession immune to their ideas, but so is the rest of the public. Although there are an alledged large number of plans in the hands of these men, they have never presented one. The Association has never got off the fence.

Some of the subordinate groups have become insubordinate due to the distasteful inaction of the medical bureaucrats and have been soundly reprimanded. One sensible position taken was that of the American College of Surgeons, yet the A.M.A. refused to countenance their suggestions.

INDUSTRIAL MEDICINE

"The American College of Surgeons has set up a 'Minimum Standard for Industrial Medicine and Traumatic Surgery' which is as follows:"

"1. That the industry shall have an organized medical department, or service, with competent medical staff including consultants and adequate emergency dispensary and hospital facilities and personnel to assure efficient care of the ill and injured."

"2. That membership on the medical staff shall be restricted to physicians and surgeons who are (a) graduates of scientific medicine holding the degree of Doctor of Medicine, in good standing and licensed to practice in their respective states or provinces; (b) competent in the field of industrial medicine and traumatic surgery; (c) worthy in character and in matters of professional ethics; that in the latter connection, the practice of the division of fees under any guise whatsoever be prohibited."

"3. That there shall be a system of accurate and complete records filed in an accessible manner..."

"4. That all patients requiring hospitalization shall be sent to institutions approved by the American College of Surgeons."

"5. A - That the medical department shall have general supervision over the sanitation of the plant and the health of all employees."

B - Physicians and surgeons, qualified as in part 2 of the Minimum Standard may properly be employed on a full time or a part time basis by industrial organizations to provide medical and surgical service for their employees as follows: a. To provide emergency ser-

vice and first aid in injury or disease, and to provide adequate medical or surgical care for industrial injuries and diseases. Medical and surgical care of the families of employees, and of employees themselves, except for emergency and industrial injuries and diseases, should be provided by the industrial physician only in remote districts where other adequate medical service is not available. b. To provide pre-employment and periodic physical examinations. c. To study the hazards of the particular industry and to cooperate with other agencies in effecting such measures as may be needed for the prevention of injury and disease. d. To keep accurate records such as may be required by local workmen's compensation laws, and so complete as to serve for scientific investigation of industrial hazards with a view to their further prevention. These records are privileged communication, subject always to due process of law.

C - The sale of a contract by an industrial organization to an individual physician or group of physicians for medical and/or hospital service for its employees encourages commercial competition and is to be condemned.

D - Unethical practice in publicity, advertising, solicitation and competition, either of a professional or financial nature, must be eliminated.

E - The accepted code of ethics of the medical profession, which is designed to protect the best interests of the patient, should apply to industrial medical service as to all other forms of medical

practice." (Christie)

This applies only to industrial medicine, but such definite statements of policy should be encouraged.

It is true that many reasonable suggestions have been made by the medical leaders, but these never have been collected and co-ordinated.

Present Governmental Attitude: (Paternalism) It is realized that the text has gone by now far from the medical problem. This is absolutely necessary in order to see the medical problem in its proper niche'. We have touched the effect of National politic in the future. Now we must face the future and the full effect of the present trend toward paternalism.

Wars recurr, it is said, because we never learn from history. Whether true or not, that statement pertains to our future, as far as governmental procedure is concerned. Time and again history shows that the decay of a nation begins with ideas similar to the "cradle to the grave" theme. The Greek and more typically the Roman Empire was destroyed from within.

PART V

GENERAL CONCLUSION AND SUGGESTIONS

CONCLUSION - RECOMMENDATIONS

After a study of the various examples of socialized medical practice it is evident that such systems are not giving medical care superior to that of the United States. We see that such theories lose their advantages under practical application. In spite of or because of our laisseze faire attitude towards medical practice, we find American medicine continually leading the world.

A similar analysis of some of the proposals for the future show fine planning, but the planning is on theory of Utopia. No one overall system is applicable to American medicine because of many factors such as population, geography, the attitudes of various groups and our traditional individualistic way of life.

It is conceded that a need exists for a better handling of the medical needs of the lower middle income group in America. However, that need is gradually being met by the expansion of systems such as the Blue Cross, cooperative hospital plans, group insurance and industrial insurance. Pre-payment or planned payment is the basis of success in all of these systems. They are all on a voluntary basis. Until now such plans have been opposed by the policy of the American Medical Association because they fear any trend toward socialized medicine.

We have come to the conclusion that there is going to be a change in the methods of medical practice. Such a change is favored by government leaders, politicians, social workers and labor leaders. They are a strong aggregation. Those groups opposing compulsory

application of an all-powerful plan to American medicine include Industry, Banking, Insurance Companies, Lawyers, small business and the medical profession itself.

Therefore recognizing a certain need and a more certain chance of having a change forced on medicine, we might make the following recommendations:

I. An acknowledgement by the profession of the need existing in the lower middle income group.

II. A formulation by the American Medical Association of a definite plan of action to take care of that need on a voluntary basis. This might include -

a. Favorable attitude toward voluntary group practice where feasable,

b. Encouragement of all voluntary pre-payment plans of individual or group insurance,

c. Enlisting the help of groups not favoring a compulsory medical system in the immediate fight against the radical change to ward socialism.

III. Make the above plan of action public. Provide means for educating the public to take advantage of complete medical care offered and preventive medicine.

IV. Continue present trends to improve the medical and educational standards.

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