

MEDICAL SERVICES UNDER HEALTH INSURANCE ABROAD

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The description of medical arrangements under health insurance in Great Britain, France, and Germany refers to the situation prior to September 1939. Since the war has disrupted mail service between the United States and continental Europe, it is difficult to learn of developments which have taken place since the outbreak of the war. Insofar as such developments have come to the attention of the author, they are included.

A REVIEW AND ANALYSIS of health insurance abroad is of value to us primarily because this form of social insurance has been developed more extensively in other countries than in the United States. The difference is, however, one of degree. We have extensive voluntary health insurance of many kinds in our own country. We also have extensive and substantially compulsory insurance systems under our State and Federal workmen's compensation laws to protect commercial and industrial workers against wage loss and medical needs resulting from accident, injury, and, to a limited extent, occupational disease arising out of or in the course of employment.

For historical perspective, we should recall that the first compulsory health insurance system was an American development. Such a system was established for American seamen by Congress during the term of our second President, through the creation of the Marine Hospital Service in 1798. The original practice of insurance contributions has long since been replaced by annual appropriations from general revenues, and the Marine Hospital Service has evolved into the United States Public Health Service.

Our first American system of health insurance developed out of the need to solve the special problems of sick or disabled seamen and to deal with local burdens in the ports. In Europe, health insurance has evolved out of similar but more general needs. Its genesis lies in man's age-old quest for security.

Before the industrial revolution, the uncertainties and calamities of life were generally due to

natural causes or to wars, and to those instabilities inherent in an agricultural and feudal organization of society. With the coming of the machine age and the growth of cities, new uncertainties appeared. Large classes of persons who were without property became dependent on small wages and found themselves unable to establish individual financial reserves against emergencies. They sought relief from some economic hazards by banding together in mutual-aid societies. They pooled their resources into common funds to provide general guarantees against individual needs.

During the first half of the last century this voluntary mutual-aid movement increased greatly in scope; many mutual insurance societies developed in the European countries and gained millions of members. Nevertheless, the membership remained small by comparison with the numbers who needed protection. There were too many societies, and many were small and financially weak; they were too numerous in cities and too few in rural areas. In spite of valuable achievements, the voluntary insurance movement remained inadequate as a general method of furnishing protection against the risks of sickness.

In 1883, Germany established compulsory sickness insurance for workers employed in commerce and industry. In the course of time other workers were brought under the system; it now covers nearly all employed persons and their dependents. In the years which followed the German enactment, the movement spread to other countries. Great Britain adopted its National Health Insurance in 1911.

During the last decade, health insurance received a strong impetus when the broad French social insurance law became effective in 1930. The Antipodes made new contributions to social

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insurance patterns when New Zealand and Australia passed their comprehensive laws of 1938. In our hemisphere, too, there have been important developments which deserve mention though they cannot yet be fully evaluated. Within the last 5 years, Brazil, Ecuador, and Peru have followed the precedent established by Chile in 1924 in adopting comprehensive health insurance laws. Health insurance in South America builds on the European patterns, but modifies them to fit special needs and circumstances.

Development of Medical Services

Health insurance, like other types of insurance, is based on two simple principles: fixed, periodic prepayment against uncertain future losses; and distribution of risks among groups of persons. Just as insurance against death is called life insurance, so insurance against sickness is known as health insurance.

In the beginning, voluntary health insurance was primarily concerned with protecting the individual against loss of earnings during periods of illness. In Europe today, though the voluntary clubs and societies of workmen have been absorbed into national compulsory systems, their original aims persist; in many countries the system is still operated mainly for the sick or disabled wage or salary earner. He receives a cash benefit to replace in part the earnings lost during his disability. In addition, he receives medical care. With only minor exceptions, medical care has become one of the essential benefits furnished under these insurance systems.

To promote recovery from illness and to restore working capacity, the worker must not only have the means to stay at home during a disabling illness lest his condition be aggravated; he must also receive the required medical services. As the competence, the complexity, and the value of medical care to the sick person increased, the cost of care rose and precipitated a need for insurance. Gradually, but steadily, the variety of medical-service benefits was enlarged and their adequacy improved, until expenditures for these services were as much as, or more than, the amounts disbursed as cash benefits. By 1933, medical-service benefits in Germany accounted for two-thirds of all benefit disbursements.

Under the British system, statutory medical benefits have remained restricted to the services

of the general practitioner and to the provision of prescribed medicines and appliances—although limited dental, ophthalmic, and other services have been developed as “additional” benefits which may be furnished out of surplus funds. But even in the British system with its limited medical services, the cost of all medical benefits combined, statutory and “additional,” accounts for a little more than one-half of total disbursements for sickness and maternity benefits.

Increasing emphasis on restoration of health—as against reimbursement of wages lost during periods of disability—led to the development of medical services not only for the insured worker but for his dependents as well. The growth and the increasing importance of medical benefits provided new opportunities for the prevention of illness and disability, and created the problem of coordinating social insurance and public health services, which had developed during the same decades but independently.

Insurance and Public Health Services

European countries appreciated the interest of the community in the prevention and mitigation of sickness and disability at least as soon and as fully as the United States. During the period in which there was expansion of public health services—in the sense in which we have been accustomed to think of them in the United States—prevention of sickness was emphasized increasingly under the insurance systems. This emphasis is to be seen in the easy and ready access of the insured person and his dependents to the medical personnel and facilities made available by the insurance organization and in the special provision of sanatoria, convalescent homes, and preventoria. The invalidity insurance systems also have played a notable role in the preventive programs.

Formerly, the concept of prevention was almost wholly associated with community-wide activities, chiefly with sanitation and the control of the communicable diseases. As those classes of morbidity which are susceptible to such activities have been substantially reduced, emphasis has properly shifted to the larger remaining field where prevention of sickness, disability, and premature death depends principally upon services to the individual. The greater the accomplishments of the traditional public health practices which are community-wide in their application,

the more important it becomes to focus effort upon preventive activities which serve the individual.

This principle is clearly reflected in the benefit provisions of most of the health insurance systems of Europe. And the accomplishments are also evident. Despite smaller economic resources and lower standards of living in some parts of Europe, the mortality rates of these countries are, in general, not much higher than our own, and—as far as we can determine—the disability rates of their insured populations bear similar relations to the disability rates of comparable groups in our uninsured population. It is not an unreasonable assumption that the statistical differences would have been much greater if those countries had left the health of their industrial population to the mercy of individual resources.

The fact that administration of health insurance has generally remained separate from public health services is not to be interpreted as lack of cooperation between the two agencies. In Great Britain, for example, practitioners notify the health authorities of cases of tuberculosis. In Germany, the sickness insurance funds and the public health authorities coordinate their activities by means of working cooperatives, on which both agencies are represented.

In the Western Hemisphere, the relationship between individual and environmental services is still closer. When health insurance is instituted in the newer countries, it begins with primary emphasis on health and medical services and with lesser emphasis on compensation of disability wage loss. A close bond is at once established between insurance and public health objectives. For example, Chile passed a comprehensive social insurance law in 1924, covering the risks of old age, invalidity, sickness, and death. In Chile, health insurance did not originate with societies of workingmen who sought protection against wage loss due to illness; it was instituted as a community measure because the death rates were unnecessarily high and because tuberculosis and other diseases—whose incidence is closely associated with socio-economic factors—were excessively prevalent.

In 1938 the original Chilean sickness insurance law of 1924 was supplemented by a preventive medicine act, which stresses the necessity for early detection and treatment of tuberculosis, syphilis,

rheumatism, affections of the heart and kidneys, and the occupational diseases. To make possible the discovery of these diseases in their incipience, all persons who are covered by social insurance are required to submit to a health examination once a year. Preventive rest cures are granted if it is likely that rest coupled with treatment will lead to recovery or to prolongation of productive life. The insured person is in a position to take advantage of this benefit, because he receives full payment of wages for the duration of the cure. The sickness insurance and preventive medicine acts of Chile are designed with special regard for the benefits which society as a whole derives from improvements in the health of the nation.

In the social insurance budget of Chile, provisions for medical and hospital services take the leading place. In 1937–38, expenditures for these services were seven times as large as disbursements for cash sickness benefits, and accounted for 77 percent of the total cost of benefits. In the development of its sickness insurance system, Chile lays particular emphasis on the construction of hospitals, the establishment of clinics, and the organization of medical centers in rural areas. In effect, where basic personnel and facilities are lacking or inadequate to preserve health or prevent illness, the new social insurance system attempts to meet these needs. It develops an integrated program, largely avoiding the traditional division of effort among public health, private medical service, and social insurance protection of individuals.

The same primary concern for improvement of national health is evident in the New Zealand social insurance law of 1938. The entire population, regardless of occupation or income, is eligible for the medical benefits authorized under the social insurance law. These benefits consist of general-practitioner service, prescribed medicines and appliances, hospital treatment, and maternity care. Additional benefits, such as specialist services, may be furnished if the finances permit. Cash disability benefits remain limited to persons who suffer a loss of income because of illness.

Provisions for Medical Services

An examination of medical services under health insurance requires, first, a review of general provisions, and second, an analysis of the special arrangements under which the medical services are

furnished. To understand the provisions for medical benefits it is necessary to have in mind the arrangements for the payment of cash benefits, and also the relationships between the two.

Insurance against wage loss due to disability follows a common pattern which shows only minor variations from one system to another. In the British system, the cash benefit is "flat"—that is, it is uniform for all beneficiaries, a fixed amount per week; in most other systems it varies with the wage of the worker, and in some it varies also with the number of dependents. The maximum cash-benefit period is always limited, most commonly to half a year. Disability lasting longer than this maximum is usually compensated under another system—sometimes called invalidity insurance, sometimes disablement insurance—which is more or less closely linked with health insurance. In all cases, a waiting period is required; the disability must have persisted continuously for at least a few days before benefits are payable. In all systems, a physician determines whether a worker is or is not incapacitated. Commonly, the certifying physician is the physician who attends the sick worker for treatment and care. Thus, the physician serves as the link between insurance against wage loss and the provisions for medical care.

In the field of medical benefits, the uniformity which is characteristic of wage-loss benefits is lacking. Instead of a common pattern, there is a wide variety of arrangements. Lack of uniformity arises, in part, from differences in the scope of the medical services which are furnished by the systems of different countries. For example, the organization of insurance services is comparatively simple in Great Britain, which confines medical benefit to the services of the general practitioner, but necessarily more complex in countries where such services as those of surgeons and other specialists, hospital care, and the laboratory are included. Lack of uniformity in the medical arrangements arises also from fundamentally different concepts as to the relations which should obtain between the insurance system and the medical personnel. The different practices which have been developed are illustrated by the salient characteristics of the British, German, and French sickness insurance systems. In the following discussion the term "medical care" is used in its narrow sense—care given to insured

persons by physicians—in order to avoid the complexity that would arise if arrangements for hospital care, nursing, dentistry, or drugs and appliances were included.

Under the British health insurance system, which limits medical care to that which may be expected from the general practitioner, only the insured worker receives medical services; his dependents are not eligible. Generally, the dependents use the same physician as the insured worker, and they pay the physician privately for services rendered. Care of the insured worker himself is remunerated by the insurance system.

Medical care under the German health insurance system includes the services of surgeons, other specialists, and hospitals, in addition to those rendered by general practitioners, and the services are available to the dependents. No direct charge for service is imposed upon the insured person, except that before going to a physician he must pay a nominal fee which entitles him to medical care for 3 months, or for the duration of the illness if it continues longer.

In contrast to the British and German systems, medical services are not actually furnished under the French system. In France, an insured person selects and continues to go to his own physician as he did prior to the introduction of social insurance. He pays the physician his fee. Then, on presentation of a receipted bill, he is partially reimbursed by the insurance fund. The amount reimbursed is four-fifths of the fees in a schedule which has been adopted by the fund. Thus, the insured person always bears one-fifth of the fees for medical services according to the schedule, plus any difference between the physician's actual charge and the corresponding fee in the adopted schedule. In recent years there has been a tendency for the fee schedules adopted by the medical associations for the guidance of individual physicians and the fee schedules used by the funds for determining the amount of the reimbursement benefit to come closer together than was the case when health insurance was first introduced. But the amount reimbursed to the insured patient need not bear any direct relationship to the amount charged by the physician. It is not uncommon for the insured patient to pay 40 percent of the cost of medical services himself and be reimbursed for only 60 percent. Occasionally, the insured person may have to pay several times the amount

which he receives from the insurance system in reimbursement.

It is inevitable that in a reimbursement or medical-indemnity arrangement the insurance fund can assume only a limited obligation for the cost of medical care. A portion of that cost, which may be small or large, remains for the individual to carry. Despite the advent of social insurance in France, medical care remains on a fee-for-service basis. Indeed, the reimbursement or indemnity pattern of the French system fails to meet some of the fundamental requirements of health insurance. Failing to give the individual assurance or security against large medical costs, it is not—in this sense—really health insurance and, in greater or lesser measure, fails to give the patient ready access to the physician.

In France, the variety of services for which the insured worker may be partially reimbursed is much like that covered by the German system. The French system provides partial reimbursement for the charges made by general practitioners, surgeons and other specialists, hospitals, and pharmacists. Like the German system, but unlike the British, the French system makes the dependents of the insured worker eligible for the same benefits as the worker himself.

An important difference may also be noted among the three systems in the duration for which medical care is granted. The British system, with the limited medical care of the general practitioner, grants the medical benefit indefinitely. The French system grants its reimbursement benefits for the first 6 months of illness; but if, at the expiration of the 6 months, the worker is entitled to an invalidity pension, the benefits are available for an additional 5 years, though dependents' benefits cease at the expiration of 6 months. In Germany, where the medical benefits are perhaps most extensive, medical care for insured workers is limited generally to 6 months within a year, and for their dependents is limited to 3 months. As an additional benefit, a number of German sickness insurance funds extend the duration of medical services for their members beyond 6 months up to a year. Medical and institutional treatment may also be granted under invalidity insurance, which is designed for long-drawn-out disabilities. But for the majority of insured persons in Germany, medical care is limited strictly in point of time.

Choice of Physician

The most important characteristics of insurance medical service are determined, in the first instance, by the policy controlling admission of practitioners to insurance practice and the choice of practitioner by the insured person.

In the three countries considered here, the principles of open admission and free choice are followed most literally in France. There, the insured person or his dependent may go to any physician who is authorized to practice medicine. Upon presentation of the receipted bill for medical services rendered, he is entitled to reimbursement. The only important limitations on free choice in France apply to consultations, the services of a specialist, surgical operations, or special treatments. Unless the special service is authorized by physicians employed by the health insurance fund, the insured may forfeit the right to reimbursement.

In Great Britain, all licensed physicians are free to engage in insurance practice. They have only to have their names entered on the local panel of insurance physicians, indicating their willingness to accept the stipulated statutory arrangements and to render the medical services which insured workers are entitled to have under the health insurance laws and regulations. The insured workers have the right to go to any physician whose name is on the local panel, subject to the limitation that a physician may not have more than 2,500 insured persons on his list, a figure which has been increased to 3,000 to meet the exigencies of the war. A physician may refuse to accept a worker who wishes to be placed on his list. The insured may change from one physician to another at any time if the change has the approval of both physicians, or he may change at quarterly intervals on his own initiative, giving a month's notice if he lacks his physician's approval.

In Germany, the principle of free choice has not always been followed. For a long time many insurance funds obtained the services of physicians on a contract basis, and in the larger cities the funds developed extensive group-clinic facilities with limited staffs. Such arrangements were strongly and bitterly opposed by medical associations. Since 1933, these contractual arrangements between individual physicians and individual sickness insurance funds have been

replaced by provisions under which, within limits, all physicians who meet stipulated requirements are admitted to insurance practice and the insured persons have free choice of the local physicians who are so admitted. The physician who wishes to engage in insurance practice must have been authorized to practice medicine in Germany, and must have had at least 2 years' experience in practice in a hospital, as assistant to an insurance practitioner in rural areas, in medico-scientific institutes, in postgraduate study, or otherwise. If a physician meets these requirements, he must then undergo a short introductory course of instruction in insurance practice.

Regulations limit the number of physicians who may be admitted to insurance practice in each locality in Germany; the maximum number admitted is one for every 600 insured workers, and the number of specialists may not exceed 40 percent of the total number of physicians. The responsibility for deciding who shall be entitled to enter insurance practice rests with a local committee of admission appointed by the Association of Sickness Insurance Physicians, an organization which has official status and includes all insurance practitioners. Thus, the decision on admission to insurance practice rests with the organized group of insurance physicians rather than with a governmental body or with the insurance fund. An appeal may be taken from the local committee of admission to the national authorities.

Duties of Physicians

The duties of insurance physicians are similar in various systems. In Great Britain, the insurance physicians are required to give their insured patients all proper and necessary medical services which are considered within the competence of general practitioners and to certify incapacity when it exists.

France attempted to preserve the private relationship between physician and patient which existed prior to the introduction of the social insurance law. However, the physician in France accepts certain new obligations when he treats insured persons. In addition to giving a receipt for fees paid, he must furnish a signed statement if he considers a consultation with other physicians desirable or if he believes that the patient needs specialist's services, a surgical operation, or

hospital care; he must aid the insurance fund in supervising patients by noting on the report slip such instructions as he has given relative to exercise, rest, confinement to the house; he must accept the disciplinary machinery of the medical association; and he agrees to issue the certificates of incapacity needed by the health insurance funds for the administration of cash wage-loss benefits.

The duties of the German insurance practitioner are more extensive than those required of physicians in Great Britain or France. He must give medical attention to insured persons, including all medical treatment and special services of which he is capable; he certifies the patient for hospital treatment; he prescribes special measures of treatment; he recommends that the patient be admitted to a convalescent home or sanatorium; he gives information about industrial and other accidents. Finally, as in Great Britain and France, he certifies disability.

Supervision of Physicians

Under all three systems, there are provisions for the supervision of the medical treatment given by insurance practitioners to their patients, but this supervision is circumscribed in order to guard against the danger of interference with the work of the physician. In certifying disability, the functions of insurance physicians depart most notably from those ordinarily performed by private practitioners. When acting as a certifying officer, the physician participates in determining the disbursement of public funds and therefore comes under the restraints necessary to safeguard such disbursements. In each country, the health insurance fund is entitled to obtain a second medical opinion as to whether or not an insured worker is disabled and should receive cash sickness benefits. The funds frequently use this privilege, particularly in cases in which the disability is of long duration. The supervision of medical care and of certification is usually carried out through separate mechanisms. Each deserves closer inspection.

In Great Britain, the review of disability certificates is the responsibility of a staff of salaried physicians known as regional medical officers. This staff is employed by the Ministry of Health, not by the health insurance societies. The approved societies, which administer the cash

sickness benefits, may at any time request the medical reexamination of a person in receipt of cash benefits, and most of the examinations performed by the regional medical officers are made upon such request. The practicing physician is invited to attend the review examination. The services of the regional medical officers are also available to the panel physicians who wish to obtain a second opinion from another physician, but these services are only rarely requested.

The regional medical officer advises the approved society whether or not cash benefits should be continued. He visits panel physicians to review, and instruct them in, recordkeeping, economical prescription of drugs, and certification of disability, and—on request—may give advice as to improved care of patients with persistent disability.

If a patient, another physician, or one of the insurance agencies charges an insurance practitioner with neglect, the complaint is referred, not to the regional medical officer, but to a subcommittee of the local insurance committee—a subcommittee consisting of equal numbers of doctors and insured persons. On the basis of the findings, the insurance committee, which includes representatives of insured persons, the doctors, and the public, decides on the penalty, which is usually a fine. In cases of gravest offense on the part of the doctor, the insurance committee may recommend to the Minister of Health that the physician be denied the privilege of insurance practice for a longer or shorter period. Before rendering a decision, the Minister refers such cases to a committee consisting of an attorney and two practicing physicians. If the complaint deals with laxity in certification, extravagance in prescribing medicines, or failure to keep proper records, it is referred to the local panel committee of physicians elected by the local insurance practitioners. From the decision of this committee there is an appeal, in the final instance, to the Minister of Health.

In France, the insurance authorities have no right to interfere in the relations between the insured and his physician. But the reimbursement pattern carries the separation of insurance and medical practice so far that the funds must invoke checks and controls to safeguard their finances. The reimbursement of excessive medical service could bankrupt the system. Accordingly, the insured person is required, on pain of losing his benefits, to cooperate with the control activities

of the insurance authorities. He must allow the supervisory medical staff of the health insurance fund to which he belongs to investigate his condition through personal interview or medical examination in his home or at the headquarters of the fund. In some of the largest funds the supervisory organizations have become elaborate diagnostic centers with staffs of specialists and with extensive laboratory, X-ray, and ancillary equipment. If it is discovered that a medical bill submitted by an insured person is unjustified or that a worker has been certified erroneously as disabled for work, the fund may withhold the reimbursement. But the physician engaged by the health insurance fund must not express any diagnostic opinion in the presence of the insured person, nor may he comment on the treatment given by the attending physician. If he disagrees with the attending physician on the condition of the insured patient, he must confer privately with the practitioner.

The French supervision of medical treatment is in the hands of the organized medical profession itself, and is exercised by the disciplinary councils of the local medical associations. Whether or not physicians are members of the medical association, they are deemed to accept this disciplinary control when they sign insurance slips for their patients. From the decision of the local disciplinary council, there is an appeal to a national council, consisting exclusively of physicians, and, finally, an appeal to a governmental tribunal, which is not exclusively medical in composition.

It will be noted that in the French system it is the insured, rather than the physician, who is closely and directly supervised and disciplined; it is the insured who may suffer a financial loss if the physician of the insurance fund disagrees with the attending physician. But, inevitably, such supervision of the insured has its repercussions upon the attending physicians. When the insurance law was being drafted, great care was exercised by the medical association to maintain undisturbed the traditional status of the French physician. However, the almost total independence left to the physician led to the development of controls which in the end are probably more extensive and more onerous than those found in countries where the insurance system actually guarantees medical service rather than reimbursement or indemnity. It is not surprising that many

physicians in France complain about bureaucratic control over their activities.

In Germany, the staff of physicians who review claims for disability benefits is independent of the health insurance funds which administer cash benefits. The reviewing physicians are employed by the regional office in charge of administering invalidity insurance, which is responsible for the payment of cash benefits during chronic or permanent disability and therefore has a vital interest in the early discovery and effective treatment of serious disease or disability. These salaried physicians not only review the worker's incapacity, but they also have a voice in deciding when a worker should receive treatment in a hospital, a sanatorium, or a convalescent home; they must be consulted when the attending physician prescribes medical appliances; and they express an opinion on whether the benefits prescribed by the insurance physicians are necessary and economical. In addition, the supervisory medical officers cooperate with other governmental authorities in matters of public health, in so-called "eugenics," and in the prevention of disease.

Under German arrangements, as under those prevailing in France and Great Britain, the supervisory medical officer may not interfere with medical treatment given by the insurance physician. He submits his opinion on the worker's incapacity and on the desirability of institutional treatment or prescriptions of drugs and appliances to the sickness insurance fund. The medical officer's opinion on questions of incapacity is binding upon the fund. If the advice of the supervisory medical officer regarding hospital treatment or prescription of drugs and appliances should be in conflict with the recommendation of the insurance physician, the fund makes the final decision.

The supervision of the medical activities of insurance physicians in Germany rests with a purely medical organization—the Association of Insurance Physicians. The Association may take action against a practitioner by means of a warning, a fine, or through temporary or permanent exclusion from insurance practice. If the measures taken by the Association against an offending member of the profession appear inadequate, the sickness insurance fund has the right to refer the matter to a higher medical board.

Remuneration of Physicians

From a professional point of view, the remuneration of insurance physicians is secondary to these more fundamental questions concerning who may furnish the medical-service benefits, the relationship of the insurance physician to the insurance fund and to his insurance patients, the supervision of insurance practice and the limits of such supervisory service. Yet the problems of remuneration have been brought into prominence by the heat of public discussion. These problems have sometimes been confused for lack of clear distinction between issues concerning the method or basis of remuneration and those concerning the amount of remuneration.

In most countries, health insurance is confined to employed persons with small incomes. Unless government subsidizes the system, the funds which are available to provide cash and medical benefits are such as can be collected from low-income groups and from their employers. The lower the limiting income of the insured persons, the more limited the financial resources. Furthermore, the lower the income level of the insured population, the larger the volume of morbidity and disability, and the greater the need for benefits. The insurance finances are, therefore, stretched in most countries to do as much work as possible, and there are only limited funds with which to pay insurance physicians. In many cases, the physicians have complained that the rate of remuneration for insurance practice is inadequate. Such evidence as is available indicates, however, that the insurance remuneration equals or exceeds the corresponding remuneration paid by uninsured groups in the population with a similar economic status.

In Great Britain, 9s. a year for each insured person is set aside from the health insurance pool for the purpose of paying physicians for insurance services. The total national sum is allocated by localities in proportion to the number of insured persons. Within each locality, the insurance physicians themselves decide the basis on which these available funds are to be distributed among them. Though the medical benefit regulations give them a choice of a capitation system, an attendance system, or a combination, the capitation method is now in general use by the physicians' own choice. Each physician receives from the fund 9s. a year per insured person for whose care he has

assumed responsibility. There are small additional funds to provide allowances for mileage in rural areas, for drugs and appliances, and for post-graduate education.

Although the French system attempted to leave untouched the traditional method of remuneration followed by patients and doctors, the adoption of a reimbursement or indemnity procedure did not wholly succeed in attaining this aim. At first, the fees in the reimbursement schedule were much lower than the fees actually charged by physicians. In the course of time, the fee schedules were revised upwards, but the physicians' actual fees have had to be lowered to approach the reimbursement fee schedules more nearly.

In Germany, the health insurance fund turns over to the Association of Insurance Physicians a lump sum which varies with the average number of members of the fund and their average wage. Introduction of the wage factor has the result of varying the remuneration of the insurance doctors from time to time and from place to place, according to the earnings of the insured workers whom they serve, though all insurance physicians are guaranteed a minimum income of 4,000 marks a year. The Association distributes the lump sum among individual physicians in accordance with agreements concluded between the Association and the local health insurance funds. The most common method has been to prorate the money in proportion to the services rendered, valuing the services according to a fee schedule. If the available money is insufficient to pay the physicians in full on this basis, all fees are scaled down proportionately. Under another arrangement, the physicians are reimbursed according to the number of cases treated. Under a third, the remuneration of the physician per case is decreased when the number of cases exceeds certain limits to discourage unnecessary attendances. Under a 1939 decree, the fee-for-service basis was abandoned for the duration of the war. Physicians receive a fixed remuneration which is computed on the basis of their income from medical practice prior to 1939. Physicians who are admitted to practice subsequent to the issuance of the decree receive a fixed daily remuneration varying with their family responsibilities and length of experience rather than with the amount of services rendered.

In summary, France has retained the fee-for-

service system of remuneration and has combined it with a system of reimbursing the patients, Great Britain operates on the per capita system, and prior to the war Germany followed an attendance system combined with minimum guaranteed income. The amount of remuneration is largely predetermined by the economic capacities of the insured population; the method of remuneration is determined by the physicians themselves. Except for periodic revision of the rate of remuneration in light of the finances of the system, the financial controversies are of only historic interest.

Conclusion

It must be evident that in Great Britain, Germany, and France, the three most important European social insurance countries, the health insurance systems have made sincere and largely successful efforts to disturb as little as possible the existing relationships between physician and patient. Within limitations not peculiar to, or arising out of, social insurance, all licensed practitioners are free to enter insurance practice. The insured turns to the physician of his choice when in need of medical care. Free and easy access to the physician is encouraged. Except for necessary limitation in each system and special limitations peculiar to indemnity schemes, the financial barrier which keeps sick persons from seeking medical care has been abolished.

In all three systems there are provisions under which professional groups review the medical activities of the attending physicians. It is precisely in France, where the practicing physicians have least direct relation with the insurance funds, that the diagnosis and treatment of insured patients are most extensively checked and supervised. This is a consequence of medical-indemnity, as distinguished from medical-service, insurance. In all three systems the physician has the duty of certifying the disabled worker for cash benefits. All three systems provide for independent review of certification by a salaried physician not engaged in competitive practice. The review of medical activities and of disability certification are responsibilities of medical organizations or of medical officers. Lay administrators have little or no direct supervision or authority over the physician; professional practitioners are primarily responsible to representatives of their own profession.

The quality of the care furnished under health

insurance systems is difficult to evaluate because there are no altogether satisfactory objective standards. One might use as a standard the quality of service formerly furnished to the same classes of patients in insurance countries before insurance was instituted. All available testimony, lay and professional, is to the effect that such a comparison is favorable to insurance. Such a comparison is obviously faulty, however, because it fails to take account of improvements in medical practice which have been occurring almost everywhere in this period. If we accept as a standard the quality of services furnished similar classes of noninsured patients by the same or by other practitioners, the record shows no clear or significant differences in quality of care. If we use the quality of medical care in noninsurance countries as a standard, the results are likewise inconclusive. Medical care in our own country, with or without insurance, provides examples in which quality is good, bad, or indifferent. If we could determine the proportions which are of one grade or another, in an insurance and in a noninsurance country, such comparisons might have value; but the author knows of no valid statistical basis for such an analysis.

Careful reports from leading physicians in insurance countries support the considered opin-

ions recorded by the professional associations that insurance has accelerated improvement in professional standards of care. Among the reasons presented by the British Medical Association to the Royal Commission on National Health Insurance in 1926 for the continuance of medical benefit were the following:

"The amount and character of the medical attention given is superior to that formerly given in the best of the old clubs"; "illness is now coming under skilled observation and treatment at an earlier stage than was formerly the case"; "speaking generally, the work of practitioners has been given a bias towards prevention which was formerly not so marked."

In the absence of objective criteria, there is, so far as the author can discover, no evidence that insurance, of itself, has affected the standards of care offered by the medical profession to a sufficient degree, one way or another, to be of determinative importance in evaluating insurance systems. There can be no question, however, that insurance has given the working population ready access to medical services which were previously available to them only to more limited extent or not at all, and that it has increased the adequacy of the medical service which the insured population actually receives in sickness.

BIBLIOGRAPHIC NOTE

The most extensive discussion in English of medical arrangements under health insurance in France, Great Britain, and Denmark is *The Health Insurance Doctor* by Barbara N. Armstrong (Princeton University Press, Princeton, 1930, 264 pp.). The subject is also treated in *Security Against Sickness* by I. S. Falk (Doubleday, Doran & Co., Garden City, 1936, 423 pp.). Some aspects of the problems presented in this article are discussed in *Organized Payments for Medical Services* issued by the Bureau of Medical Economics of the American Medical Association (1930, 185 pp.), and in current notes and correspondence in the *Journal of the American Medical Association*.

Industrial and Labour Information and the *International Labour Review*, two periodicals of the International Labor Office, and the *Revue Internationale de Médecine Professionnelle et Sociale* have been used extensively in the preparation of this article.

The most exhaustive work on health services in Great Britain is the *Report on the British Health Services* issued by Political and Economic Planning (1938, 430 pp.). The *British Medical Journal* and the *National Insurance Gazette* report periodically on developments in this field. The *Report of the Royal Commission on National Health Insurance* (London, His Majesty's Stationery Office, 1928)

and the British Medical Association's *A General Medical Service for the Nation* (London, April 1938) have also been consulted.

The *Bulletin de Documentation* and *Le Médecin de France* contain current information on the subject of medical services under health insurance in France.

Important sources of material on medical services under German sickness insurance are:

Taschenbuch des Vertrauensarztes by Dr. Th. Vatermann (Julius Springer, 1936, 107 pp.); *Die Arbeiten des ersten internationalen Kongresses der Sozialversicherungsfachleute*, Budapest, 1935; *Bericht über die Arbeiten des Dritten Internationalen Kongresses der Sozialversicherungsfachleute in Wien vom 18. bis 22. Mai 1938* (Carl Ueberreuters Verlag, Wien, 1938, 291 pp.). In addition, articles in the following periodicals on the relationship of the physician to sickness insurance in Germany have been used in the preparation of the article: *Deutsches Ärzteblatt*; *Deutsche Medizinische Wochenschrift*; *Die Ortskrankenkasse*; *Die Landkrankenkasse*; *Reichsarbeitsblatt*; *Die Arbeiter-Versorgung*; *Monatsschrift für Arbeiter- und Angestelltenversicherung*; *Soziale Praxis*; *Die Sozialversicherung*; *Das Versicherungsarchiv*; *Volkstümliche Zeitschrift für die gesamte Sozialversicherung*.