

Compulsory Medical Care
and
The Welfare State

COMPULSORY MEDICAL CARE

AND

THE WELFARE STATE

By

MELCHIOR PALYI

*An Analysis based on a special study of
Governmentalized Medical Care Systems on
the Continent of Europe and in England*

SPECIAL EDITION

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Concerning The Book and The Author

THE DOCTRINE of the Welfare State is being offered in the United States as a bright and shiny new invention. It is being accepted by some on the assumption that it is a device with inherent capacity to solve the complicated problems of mankind,—the accumulation of the misdeeds of countless generations of men.

The term "Welfare State" has pleasant connotations. It carries the implication of a deep concern for the welfare of human beings and conveys the impression of a boundless compassion and a benevolence without limitation. Dr. Palyi, in the first chapter of his book, *COMPULSORY MEDICAL CARE AND THE WELFARE STATE*, realistically points out:

"In democracies the Welfare State is the beginning, and the Police State the end. The two merge sooner or later, in all experience, and for obvious reasons." *He further states that* "all modern dictators have at least one thing in common. They all believe in Social Security, especially in coercing people into governmentalized medicine."

For more than ten years there has been under way a relentless drive to impose a Nationalized Medical Service on the American people. This would represent a truly revolutionary innovation. Yet, until the publication of this book, there was not available either in Europe, America or anywhere, a comprehensive survey on Compulsory Medical Care in various countries. There was certainly none that attempted an appraisal of, or that would do justice to, developments in this field during the last two decades. In the available literature the emphasis is overwhelmingly on the legalities and technicalities rather than on an analysis of the major economic, political and social implications and resultants. In this book, Dr. Palyi has provided an authentic historical record and such an analysis.

Dr. Melchior Palyi is an American citizen of Hungarian descent—a distinguished, internationally recognized educator, author, economist and financial expert. He taught in the Universities of Kiel, Goettingen and Berlin. In 1928 he was appointed Chief Economist to the Deutsch Bank in Berlin. From 1931 to 1933 he served in the capacity of Scientific Advisor to the Reichsbank of Germany.

For almost twenty-five years, Dr. Palyi lived with and observed the ebb and flow of “power politics” in Europe.

In this country, he taught at the Universities of Chicago, Wisconsin and Northwestern. He acquired a national reputation as a scientific and popular writer, public lecturer, radio commentator and consulting economist. Two recent trips through Western Europe in the summer of 1948 and in the spring of 1949 were devoted, the first in part and the second entirely, to a study of developments in the field of compulsory medicine.

Dr. Palyi deals with the introduction, growth and extension of governmentalized medical services on the Continent and in England. He makes clear how these services have been used in all countries to augment and strengthen controls by politicians and bureaucrats. In addition, he has provided insight into the origin and development of Welfare State doctrine and deeds.

During the past few years most Americans have begun to comprehend that vast revolutionary forces are in ferment in this country. It must be understood that the establishment and extension of Welfare State concepts and mechanisms lead to an inevitable end. If implemented here, they ultimately would mean for America the blind confusion that is Europe, the tragic austerity that is England and the Godless despair that is Russia.

THE PUBLISHERS.

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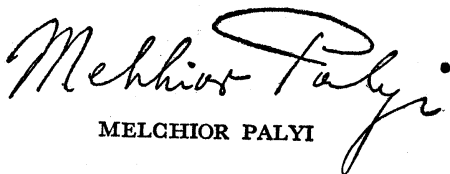
Author's Preface

An aspect of the so-called Welfare State is the subject of this study. Its objective is analysis. Telling the relevant truth, even if it is disillusioning to the author himself, constitutes the scientific approach. Whether one believes in the Welfare State or not, whether one prefers some form of governmentalization in medicine or not are matters of basic philosophy. But the rational man submits his convictions to the acid test of experience. The purpose is to apply the test. The reader may draw his own conclusions.

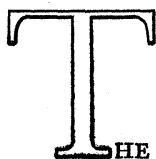
The author is fully aware that documentation at every point could only have been presented in this volume by the addition of appendices which would have swamped the reader.

This study could not have been completed in the very short time at my disposal, without the stimulating advice and help of European experts, including scheme and panel officials, doctors, businessmen and others. Naming them individually is prohibited by their large number. But acknowledgment is due my secretary, Miss Colina Clow, for her help in the arduous technical job involved, and Miss Elenor Galusha (Chicago) for her thorough work in editing the manuscript.

Chicago, December, 1949.


MELCHIOR PALYI

Rendezvous with the Welfare State



THE ESSENTIAL idea of the Welfare State is as old as known history. Its concept and mechanism—the systematic dispensing, through political channels and without regard to productivity, of domestic wealth—were at the very core of the Greco-Latin city states, of the medieval city, and of the post-Renaissance absolute monarchy. In the city republics, ancient and medieval, it meant bloody civil wars. Their constantly recurring violent quarrels about constitutional issues disguised bitter class-warfares to seize the power that was dispensing all benefits. Most of them went on the rocks of their internal struggles for economic privileges. A Lorenzo Magnifico in Florence or the Oligarchy of the Ten in Venice managed to “save” their cities—by grabbing the power and robbing the citizens of every vestige of political freedom and civic rights. Jacob Burckhardt’s allegation that the orgy of paternalism under Emperor Diocletian resulted in governmental money recipients larger in number than the taxpayers, might be applicable to many other doomed civilizations.¹

“A CHICKEN IN EVERY POT” France’s Henry IV in the 16th Century promised a chicken in every pot. Her brilliant Colbert in the 17th century and Prussia’s enlightened Frederick the Great in the 18th, these forerunners of modern dictators, gloried in calling themselves the first servants of the nation. Their Police State used the Welfare State as its instrument, facade and justification, as do modern dictatorships. In democracies the Welfare State is the

beginning and the Police State the end. The two merge sooner or later, in all experience, and for obvious reasons.

The "mercantilist" princes of the 16th to 18th centuries developed the basic tenets of the modern Welfare State in a piecemeal fashion. Originally their prime concern was the balance of trade—the want of gold and silver. To that, domestic policy was subordinated, except when political motives were uppermost, such as the fear of hunger riots which occurred time and again in England under the Tudors and Stuarts, forcing them to dispense humanitarianism. The craving for export surpluses led logically to promoting production. Amateurish Welfare policies followed and soon became a determining factor in domestic politics.

THE WELFARE-POLICE STATE In Central Europe the 18th Century was marked by the "Despotism of Virtue," exercised by benevolent rulers like Joseph II of Austria. The intolerance and intransigence of the "humanitarian tyrant" had no small role in provoking revolutions. The German *kameralists* of the period, who taught the technique of civil government, developed systematically the blueprint of the Welfare State (*wolfsahrt staat*) of a territorial scope, far beyond medieval city limits and as the heart of the Police State (*polizei staat*). Even the words are 18th Century German. This tradition of bureaucratic rule—for the alleged good of the subjects—was the heritage taken over by Bismarck.

Bismarck's fundamentally significant role in modern history is rarely understood. His middle-of-the-road socialism was the connecting link between the old autocrats and the coming totalitarians. He thought he could overcome Marxism by his own brand of state socialism—just as Fabian socialists, Keynesians and New Dealers profess that their middle-of-the-road statism keeps the totalitarian wolf from the door.

What Bismarck did accomplish was to revolutionize the old authoritarian school by giving it a quasi-democratic twist and by basing it on a superbly organized, technically well-trained and thoroughly disciplined bureaucracy. His Police-Welfare (or Welfare-Police) State had firm roots as none had had before. The substance of a military monarchy was wrapped in a parliamentary cloak. Share-the-wealth popularity was to

be dispensed legally by an all-powerful and efficient administration.

WELFARISM IN OPERATION

Even more interesting than to follow the historical records of the Welfare State is to witness directly its contemporary gyrations and its ties with other facets of public policy. This writer was "conditioned" to the problem by early acquaintance with the petty inside-politics in the Welfare Monarchy of the Habsburgs. His conscious interest dates back to his studies in German universities from 1910 on, when the great masters of the German Historical School still were exerting intellectual leadership. The German public, and most Europeans for that matter, stood under the spell of Bismarck's forceful personality, without realizing where that spirit was leading. The intelligentsia was infatuated already with the then still misty ideal of the welfare-dispensing Iron Power. So was the populace on the street.

It was my good fortune, in particular, to come in close contact, as their student and assistant, with the two most original thinkers and most brilliant personalities of the period: Lujo Brentano and Max Weber, the foremost social scientists of their age. They were scholars of encyclopedic scope and of statesmanly stature, animated by the ethos of their belief in Liberty and Justice. As true Liberals, they stood in matters of labor policy for trade unionism, the eight hour day, and for factory legislation, as far as compatible with domestic free enterprise and international free trade. They were opposed to dogmatic laissez-faire—which meant paternalism in labor relations—as well as to paternalism in government. Realizing that history is the record of the eternal battle between the Power and the People, they saw clouds rising that most of their contemporaries ignored: the aggressive economic nationalism and the congealing, overbearing bureaucratism of the Neo-Welfare State. They saw the unique part Bismarck's Second Reich played in the revival of authoritarianism and fought it as a threat to the progress of occidental civilization.

As early as 1881, Lujo Brentano warned that adventuring into governmentalized medicine is the first step toward the Neo-Welfare State, which in turn opens up a road to national catastrophe—in the long run.² The run was too long and too slow to be understood. Other more urgent problems occupied

our minds. The warning was practically forgotten by 1919 when I gave my first courses as an instructor at the Munich Graduate School of Commerce on Insurance and on Cooperatives. Compulsory medicine seemed to be well established and a minor problem. In-between years, spent on (unfinished) medical studies, provided no inkling of its practical functioning. The prevailing academic pattern naively accepted a governmentalized pseudo-insurance as a chapter of *sozialpolitik* (welfare policy), differing from other insurance only by its non-profit character. And it was defended as an alleged necessity in industrial society.

INTERMEZZO We were preoccupied with the Versailles treaty, the great inflation and domestic and international reconstruction and the sweeping out of the moral and material debris left over by Ludendorff. Europe's fatal fourteen years of transition after World War I began under the Lenin nightmare and ended with the Hitler chimera. True liberals were driven into an unholy and futile alliance with the middle-of-the-roaders.

After years of experience and study in international banking and public finance, I began to see that what most of my academic colleagues accepted and defended as an accomplished fact, the Bismarckian Social Insurance, was worm-eaten at its very roots. What have "high finance" and international affairs to do with the poor man's compulsory social insurance? A great deal, as I found out, and with more than finance. For one thing, the social insurance funds gave the welfarist Weimar government a dangerous foothold in the nation's capital market and taught it to grab for other footholds.

For another thing, I stumbled upon the discovery that German compulsory medicine was more expensive than private health insurance and gave less in exchange. On top of that, it was badly infected with corruption.

Insight into some of these shortcomings came about through my friendship with an outstanding socialist leader, old Eduard Bernstein. He was one of the three or four early apostles of the Marxian creed. But he lacked the fanatic dogmatism of the others. He became famous by speaking out in the '90's what

every Marxist knew and none dared to say—that history was not marching according to the time-table of the class-warfare theory. For this, he was temporarily ostracized by his own party. Through his honest eyes, I began to see that everything was not in order in the medical Utopia. The more I looked into it, the more disquieting the picture became.

FROM WEIMAR TO HITLER

The Welfare State was moving into the great depression. My work at the very center of German and international banking put me at a vantage point from which to observe closely the world-wide growth of Welfarism. It was intimately tied up with the political scene of the 1920's, with its global money management and fictitious pacifism. It was supported by monopolistic wage structures, governmentally promoted international cartels, inflated gold exchange standards, by a centrally manipulated capital flow on the one end and by reckless spending on the other. It had to break down sooner or later.

In many ways Hitler's rise was startlingly revealing. That one-third of the otherwise sober German people voted Nazi, and over 10% Communist, was bad enough. But what about the rest, the three or four *bourgeois* parties and the Social Democrats? Why didn't they resist instead of letting the power slip without a single shot into the hands of notorious gangsters? The Social Democrats and the trade unions behind them constituted the world's oldest, largest, best organized and most intelligent labor movement. Why did they surrender shamefully and let themselves be disarmed?

The Weimar Republic catered to the trade unions and raised the wage level artificially, at the same time bestowing subsidies and high tariff protection on the heavy industries and the big land-owners, the Prussian *junkers*. Once a nation is entangled in the meshes of the Welfare State, the demagogue who can draw out of his hat more welfare for more people has every chance in a crisis. The Bismarckian paternalism could be turned into Ludendorff's Planned Economy by a mere switch of the bureaucratic gear, which then could be shifted without grinding into the Welfare State of the Weimar Republic. As that got into trouble, the ultimate of demagoguery, the combination of ultra-nationalism and super-welfarism, had a field day. By that time, the socialists as well as the middle classes

were so intoxicated with the ideas of an allegedly inevitable state paternalism that the moral fiber had become too weak to generate resistance.

HUMANITARIANS IN DISGUISE

Perhaps the most spectacular "social" aspect of Nazism was its emphasis on health, as part and parcel of a racial nationalism. That was not accidental. The health, or rather sickness, propaganda employed by Bismarck elevated that aspect of social welfare to a prime political issue. Just why were such ruthless men as Bismarck and Hitler so profoundly interested in the physical well-being of their subjects—and in high birth-rates!—while totally indifferent, nay, inimical to their mental integrity? But after a fashion so were their predecessors in the Mercantilist age, especially the ministers of the imperialistic Bourbons and the power-lusty Hohenzollerns. And so are their successors to this day.

Evidently, more than humanitarianism was at stake. Watching the world-wide growth of compulsory health insurance, from Icelandic fisherman to coal miners in China, I noticed something that seemed to be overlooked: that all modern dictators—communist, fascist, or disguised—have at least one thing in common. They all believe in Social Security, especially in coercing people into governmentalized medicine.

A *selected list* of men who have claimed credit for, or have been credited with, introducing or strengthening and expanding governmentalized medical care reads like an extraordinary Who's Who:

Prince Otto von Bismarck, Chancellor of Germany (1884);

Franz Joseph I, Emperor of Austria (1888);

Franz Joseph I, King of Hungary (1891);

Wilhelm II, "the kaiser" of Germany (1911);

Admiral Miklos Horthy, reorganizing the scheme as Regent of Hungary (1927);

Nicholas II, Czar of Russia (1911);

Vladimir Lenin-Ulianof, founder of modern dictatorship in Soviet Russia (1922);

Joseph Stalin-Dzhugashvili, almighty Prime Minister and dictator of the U.S.S.R.;

Joseph Pilsudski, Marshal and para-dictator of Poland (1920);

Alexander I, King and dictator of Yugoslavia (1922);

Antonio de Oliveira Salazar, the professor-dictator of Portugal (1919 and 1933);

Benito Mussolini, Prime Minister and the Duce of Italy (1932 and 1943);

Francisco Franco, military dictator of Spain (1942 and 1945);

Yoshihito, Mikado of Japan (1922);

Hirohito, Mikado of Japan (1934);

Carol II, pseudo-constitutional King of Romania (1933);

Joseph Vargas, President and would-be dictator of Brazil (1944);

Juan Peron, President and boss of the military *junta* of Argentina (1944);

Adolf Hitler, Chancellor, the *führer* of Germany (1933, etc.);

Pierre Laval, Prime Minister of France (1930), later executed for his fascist activities;

Ambroise Croizat, Communist Minister of Labor in France (1945);

Georgi Dimitrov, the late chief agent of the global Comintern, Premier of sovietized Bulgaria (1948);

Josip Broz, alias Tito, Prime and Foreign Minister, dictator, general secretary of the Communist Party of Yugoslavia (1947);

Boleslaw Bierut, President and dictatorial figure-head of Satellite Poland (1947);

Klement Gottwald, President of the Sovietized Republic of Czechoslovakia (1948).

This list of power dynamos—or symbols of power—with bleeding hearts for human suffering is by no means complete. Complete data on some of the Satellite and Latin American bosses are not available. Some others are missing because they do not qualify technically for membership in the club of recognized full and semi-dictators and of paternalistic rulers “by the grace of God” or otherwise, having been elected in ordinary

democratic procedures and still exposed to new elections. But who would have foreseen that an easy-going, money-grabbing politician like Laval was to become a sort of second-hand Mussolini? Most certainly Laval claimed and wielded, about 1930, less than a fraction of the discretionary and arbitrary power the British Health Minister wields at this writing. And there are more Pierre Lavals and Aneurin Bevans around in what we call the democratic world than the unsophisticated might assume. They manage to be re-elected again and again and strive to rule by blank delegations of power, immune from judicial controls and supported by rubber-stamp parliaments typical of "advanced" Welfare States of 20th Century vintage.

SOCIALIST NATIONALISM Indeed, out of the ashes of the Welfare States that went down unsung in the tumultuous depression new and much more imposing ones have risen since. It seems that history is running in cycles, progressing from what is known as National Socialism to what is recognized as Socialist Nationalism.

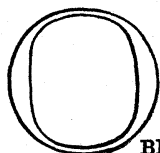
Ever since Bismarck, great dictators and little demagogues compete with one another and with the humanitarians in courting the favor of the ailing, the lame, the blind, the poor, the underprivileged and the aged. In World War I, Ludendorff used Germany's social insurance, then Europe's most "progressive," for propagandizing Teutonic social and cultural superiority. Today, British and French propagandists vie with each other in eulogizing the respective security plans. But Stalin outdoes all of them. "Government insurance in the U.S.S.R. is a source of pride of the Soviet workers before the whole world. It is one of the jewels in the colossal edifice of Socialism. It is one of the testimonials to *Stalin's deep solicitude for his fellow men* by which we are all warmed and heartened," said *Trud*, the organ of the Soviet trade unions, in 1937.³

The great French visionary, Alexis de Tocqueville (*De la Democratie en Amerique*, 1840), warned more than a century ago that democracies like ours may succumb to a new and soft technique of governmental benevolence that subdues all individuality. The suspicion that the solicitude of notorious tyrants for the welfare of their subjects must have something to do with the political nature of the medical security systems was one consideration that inspired this study.

*"It is not easy to be a Kaiser
under such a Chancellor."
Emperor Wilhelm I.*

C H A P T E R T W O

From Bismarck to Lenin: Origin and Rise Of Compulsory Medicine



OBLIGATORY health insurance started moderately enough—in Prussia. Compulsion under a law of 1845 was left in the hands of municipal administrations, with no government subsidy involved, and no contributions from employers. The anti-socialist law of 1878 suppressed many of labor's voluntary associations for sickness benefits. The next step was the governmentalization of the associations' functions.

BISMARCK'S OBJECTIVES It was no mere accident that the ideological forefathers of Nazism, Adolf Wagner and Eugen Dühring, happened to be the "brain trusters" behind Bismarck's "nationalistic socialism to end international socialism," using his own terms. When, on January 1, 1884, his compulsory sickness scheme went into operation it literally started a new era—a new age in the history of Welfarism.

Bismarck's role in modern history is rarely spoken of now-a-days. Undoubtedly, his political and administrative "genius" has shaped history down to our times. His revolutionary innovation in welfare policy was preceded five years before, in 1879, by the imposition of a protective tariff that started Europe's internecine commercial warfare which endures to this day. And it was followed by the introduction in 1889 of universal military service covering even the middle-aged manhood. This started a rearmament race leading into total wars with the objective of annihilating entire nations.

The shrewd Iron Chancellor—the dictator in constitutional disguise, quoting M. J. Bonn's epigram¹—meant to kill several birds with one stone when he embarked on his program of appeasing labor. The reason, announced in the November 17, 1881 message of Emperor William I, to offer something positive to labor, not merely the repression of socialists by police force, may have been born of genuine worry over the unrest of the working classes due to the long depression that had engulfed Europe since 1875. But the true motive has been pointed out in the penetrating Bismarck biography (Vol. III, pp. 370-71) of Erich Eyck: "To his mind the State, by aiding the workers, should not only fulfill the duty ordered by religion, but it should obtain in particular a claim on their thankfulness, a gratitude that was to be shown by loyalty to the government and by loyal pro-government votes in elections." In other words, it was the old-fashioned attempt of the monarchy to ally itself with the *plebs* against the "aristocracy" in between the two. However, the social insurance legislation did not stop the Marxists from returning in increasing parliamentary strength. The attempt to subdue the socialist movement by appeasement ended in a political fiasco.

Prince Bismarck found other satisfaction. The state socialism of His Highness was directed against the business interests and the Liberal (free trade) Party. The latter had accepted the principle that workers should be forced to insure themselves but stood for their freedom to choose their own, non-governmentalized agencies. What was even worse from the militarist point of view, the Liberals were blocking time and again the Chancellor's requests for armaments. The Reich he created had almost no revenues of its own other than from import duties and excises. It had to rely on contributions from the states which were available only through unpleasant parliamentary procedures. The new social insurance organizations were to place their resources at the federal government's disposal, saving Bismarck the embarrassment of going, when need arose, with his hat in hand to a reluctant Reichstag.

Above all, the new system was an offshoot of his economic and political philosophy. Bismarck was a tradition-bound reactionary, altogether resentful of modern industrial development, although he himself owned a small paper mill. As did many of the ultra-conservative contemporaries of his *junker*

class, he trusted agriculture and handicraft but frowned on large-scale industrial enterprise and on trade unionism. To check both, if they had to be tolerated, was one of his goals. Governmentalizing and thereby controlling, through an appropriate bureaucratic apparatus, the providing of medical, accident and old age care and of death (burial) benefits seemed an obvious way to put the reins on laissez-faire capitalism as well as on labor.

THE SPREAD OF THE IDEA

This approach conformed to the paternalistic make-up of his mind—as it conforms to the paternalism of modern dictators and of humanitarian social workers. It is no mere accident if pseudo-liberals bubble over with praise of the arch-reactionary Prussian *junker's* medical security legislation.² It was especially palatable to the bureaucracy of the Habsburg Monarchy.

The West resisted at first. It still was imbued with the 19th Century tradition of individual freedom and responsibility. But even before World War I its resistance began to soften under the fascination of the power emanating from Wilhelminian Germany and under the German propaganda that labor's patriotism has to be bought by social concessions. Shortly before or during that war, Britain, Norway, Iceland, Russia (!), etc. introduced modified replicas of the German compulsory panel system, followed by more countries after 1918. A dead and defeated Bismarck proved to have a wider spiritual influence than the living and victorious one ever enjoyed.

The triumphant march of authoritarian medicine received a fresh boost at the outset of the great depression when, among others, France, after a decade of political oratory and wrangling on the subject, instituted a system of its own. It was modeled on the German but with significant modifications.

However, 1943-46 was the most crucial time since 1881-84 in the Western history of compulsory health service. It was the hour of the liberation from Nazi occupation, with the parliamentary systems of the liberated nations in a semi-chaotic condition, and with Communists either in cabinet posts or having decisive influence in public affairs. As a result, far-reaching legislation was hurried through, which under normal conditions, would have run into serious obstacles. In France,

in November 1944, a new social security law of communistic coloring was voted in a virtually empty Chamber of Deputies. Left-wing rule in Belgium was responsible for its sickness scheme of 1944. It was also under abnormal wartime and post-war conditions that Italy and Holland "reformed" their sickness plans. New plans were put into operation or the old ones were revamped thoroughly in Australia, Argentina, Brazil, Chile, Spain, the Russian satellite countries, Costa Rica, Ecuador and of course in Britain. Legislation has been passed, but is not as yet in effect in three Canadian provinces and in Sweden.

HITLER, THE HUMANITARIAN

It is a fact, and a very remarkable one, that the great demagogues of our age appear to be greatly worried about the health of their subjects. No one was more so than Adolf Hitler. His racism was the last word in "biological" demagoguery, unless the new anti-hereditary biology of the Soviets exceeds it, an expression of the identical nationalistic purpose. In terms of political results, it was a most effective demagoguery due to its emphasis on health and virility. As a committee report on health insurance of the Canadian House of Commons put it (March 16, 1943): "During the early years of Hitler's regime, the government's medical program was looked upon by many observers as one of the greatest props of the totalitarian state."

Before coming to power, the Nazis were violently critical of the social insurance set-up, considering it a weapon in the hands of their enemies, the Social Democrats. They objected especially to the extravagance and corruption in compulsory medicine and to its alleged effect in "softening" German manhood. Thereby they earned the applause of doctors as well as of businessmen and the approval of the disgruntled middle classes. They promised thorough-going reform and drove their opposition home so forcefully that Chancellor Brüning was constrained to introduce in 1931-32 several measures affecting the medical care system which were most unpopular with labor. A three-day waiting period before cash benefits became available was made mandatory. A small tax ("deductible") on prescriptions and a levy of 50 pfennigs on each quarterly sickness ticket of the patient were imposed. This charge of 20 cents in American money per

quarter, imposed on patients many of whom were unemployed, resulted at once in cutting the number of applications by about one-quarter! But these "deflationary" measures, together with the liquidation of the totally bankrupt unemployment insurance, also had the consequence of arousing an ill-feeling among the workers which had no small influence in bringing down the house of the Weimar Republic. Brüning took the blame; Hitler got the credit.

Once in power, the latter soon reversed his strategy. The ill-famed Dr. Ley, boss of the Nazi labor front, did not fail to see that the social insurance system could be used for Nazi politics as a means of popular demagoguery; as a bastion of bureaucratic power; as an instrument of regimentation, and as a reservoir from which to draw jobs for political favorites and loanable funds for rearmament. Brüning's extra tax on panel patients was cut in half. By 1935, with Hitlerian full employment under way, the few pennies of extra tax represented a purely nominal charge. The sting was taken out of it.

The *führer* gained in popularity by reducing to negligible proportions an unpopular measure which he himself had instigated. He lost no time in making a positive contribution of his own to the organization of compulsory medicine by extending it in 1939 to small business (handicraft), by tightening it in Austria (1938) and by establishing compulsory health care in occupied Holland (1941). One of his last "social" measures, in March 1945, was to have workers in certain irregular types of employment included. But his attempt to abolish the autonomy of the panels and to regiment them by centralization had been checked by the concerted resistance of the medical profession, the panel bureaucracy and public opinion. Similar abortive attempts at complete bureaucratization of the panels were made under the Kaiser in 1909 and in the Weimar Republic's revolutionary days in 1919. The same goal is on the Social Democratic Party's agenda again in 1949.

FORCING FRENCH LABOR INTO SCHEME

The original schemes of compulsory medicine have been imposed on the respective countries without the consent and often against the very vocal resistance of those who were supposed to benefit. That was the

case in Germany and also in France. The following is a good summary of what happened there:³

"Social insurance was introduced in France on a really universal scale by the Law of April 5, 1928, which later was amended by the Law of April 30, 1930. At that time it was believed that this was the crowning piece of work completing the entire edifice of French social legislation. Its application nevertheless met with strong opposition culminating in strikes and violent labor disturbances in several industrial districts, particularly in the Northern Roubaix-Tourcoing region. Labor resented the 4 per cent tax imposed upon wages, and the immediate hardship outweighed in its eyes the possibility of future benefits. Not only did the communists immediately seize upon this occasion to foment strikes by interpreting the new measure as being purely and simply a tax on payrolls, but even the socialists joined the opposition, arguing with a certain degree of justification that the increased price of finished products resulted in all-round higher cost of living, superimposed upon the reduction of salaries.

"It is of interest to note in connection with the early strikes that the textile consortium of Roubaix-Tourcoing offered to pay the employees' share of the tax for all operatives employed for over one year. Strangely enough, this proposal met with especially violent labor opposition in spite of its obvious justification by the greater skill and experience of steadily employed workers, compensating employers for the supplementary charge which they offered to undertake. The efforts of M. Laval were at that time successful in bringing about a compromise solution.

"The law met, moreover, with much less spectacular but perhaps even greater difficulties from passive resistance. In 1933, for instance, it was not applied to some 3,470,000 workers, mostly operating for small concerns having not more than five employees. Excessive bureaucracy, opposition of labor and carelessness were principally blamed. Enterprises complying with the law were soon menaced by sharper competition from the non-observers. These were later converted to a more conciliatory attitude by stricter control and penalties."

Just as the German workers did half a century earlier, the French resisted being forced into a humanitarian scheme. Their trade unions recognized that they would have to pay the price themselves in the form of contributions and increased costs of living. But the real reason for opposition was political rather than economic. They understood that a tremendous power position and a new bastion of bureaucracy were being built up at their expense. Accordingly, they made an about-face in 1944-45 when the scheme was to be reformed, i.e., expanded under a pro-communist regime. By that time the trade unions were to be vested with the power which before they had so energetically opposed.

LENIN ENTERS Of all totalitarians who have written their names in the book of medical economics and politics, Lenin's will have to be printed in the largest capital letters. His was (1917) the first complete cradle-to-grave plan, the first plan embodying complete nationalization of medicine. His influence on the West did not make itself directly felt until World War II. Since then, wherever Russian bayonets take over, the Soviet blueprint of social security follows. Even more important to us is his ideological influence, embodied in the Beveridge Plan of 1943, that in turn appears to be spreading over Western Europe, Latin America and the Antipodes.

*"The Few assume to be the deputies,
but they are often only the despoilers
of the Many." Hegel, Philosophy of History.*

C H A P T E R T H R E E

From Lenin to Bevan: Streamlining the Health Schemes

LENIN and Bismarck had in common the paternalistic philosophy of government which included the supremacy of a trained and solidly disciplined bureaucracy over what they both considered the anarchy of the unregimented market place. To both, the "little man" was either financially or at any rate morally incapable of caring for his own future. Both were motivated by an insatiable thirst for power and utilized to their own political advantage the alleged responsibility of the State for controlling the insecurities of industrial life. Social Insurance or Social Security was essential to their concept of the Good Society. It involved a regimented society ruled by their own superior wisdom.

FROM SOCIAL INSURANCE TO SOCIAL SECURITY

Actually, Lenin and his followers were thorough-going admirers of the Prussian bureaucracy. Soviet planning was built, at the outset, on the pattern of German military management in World War I. But there the ideological community of the two authoritarians ended. Bismarck presented his project in the name of the Christian idea of the State, confusing it with the state idea of 18th Century enlightenment.¹ (His much vaunted "Christianity" did not interfere with Bismarck's violent opposition to any sort of factory law, such as to enforce minimum hygienic requirements.) Lenin was a genuine revolutionary, basing his communism on a purely materialistic philosophy. To the one, private ownership of the means of production was sacrosanct but was to be regimented; for the other, it was to be wiped out altogether.

Bismarck had to compromise with resisting parliamentary forces led by the industrialist Stumm. Even the trade unions were opposed tooth and nail; they could not foresee—nor did Bismarck, of course—that some day they themselves would have the power to use the scheme for more power. Lenin, by 1922, having wiped out parliamentary resistance, possessed power absolute as no sovereign has had since Genghis Khan.

Two basic types of governmentalized medicine resulted. The Prussian bureaucrat created the obligatory health insurance of a comparatively limited scope. What the Russian Bolshevik has bestowed might be described—following recent Anglo-French terminology—as compulsory health security of an unlimited medical orbit. Perhaps they should be distinguished as governmentalized vs. socialized medicine. In the one, the beneficiaries are “insured”; in the other, they are “registered.”

That Social Insurance à la Bismarck, and Social Security à la Lenin are different in degree only—that the dynamic potentials of the one tend to carry over into the other—may astonish those who do not realize that Bismarck’s famous “personal rule,” that was to wreck his nation’s democracy, was a conscious if abortive attempt aiming basically at the same political goal which was to materialize in the Politburo (and in Hitlerism).

LENIN vs. BISMARCK Bismarck’s system meant to be, in appearance at least, what its name indicated: insurance, even if without a true actuarial foundation, and a subsidized, involuntary plan. At the outset, the insured were to be classified according to risks and to receive cash benefits in proportion to their contributions; a surplus, the equivalent of profit, was to be accumulated as an emergency reserve to guarantee the insurers’ (panels’) solvency; each type of risk incurred was to be offset by appropriate premiums; preferably, the risks were to be distributed by re-insurance; etc. These are axioms of sound insurance management, most closely approximated at present by the Swiss panels among European cooperative systems of medical care.

Nothing of the kind is aimed at in the Bolshevik pattern, the all embracing program of Comrade Lenin. The same holds in principle for the compulsory set-ups based on Lenin-

ian security ideals now in operation in France and Britain. There, too, the pretense of businesslike management has been almost totally abandoned.

Bismarck's humanitarianism was limited originally to the worker dependent on hourly wages. Thus the range of persons falling under the compulsion was defined. This type of legislation, which still predominates on the Continent, restricts panel membership to employees and their families, or to the "economically weak" groups comprising the income brackets not above skilled factory labor.

THE SOVIET PANACEA

In Lenin's kind of world there is, supposedly, one kind of income recipients only. All are in the same boat; all need the same support. The idea of medical insurance for the underprivileged is inflated into equal medication for everybody. Every one according to his needs, is the underlying axiom. From a humanitarian device of restricted confines, the idea has grown into all-embracing, communistic dimensions—on paper. In reality, the industrial population only is "secured."

In Soviet Russia, from 1922 to 1938, nationalized industry—i.e., the government—carried the cost of socialized medicine in the form of a 6.5 per cent "payroll tax" (25 per cent for all social security) with recourse on the national budget to cover eventual deficits. Industries, not labor, were to pay the bill. Similar systems with minor modifications are now being set up in the satellite countries. In the 1948 Bulgarian scheme, for example, the self-employed are the only ones to pay contributions—which is one way to hasten their elimination—with all benefits of medical service freely dispensed to every one.

Of course, Lenin's promises and Stalin's practices are worlds apart. Since 1938, the trade unions, the workers, had to take over about 8 per cent of the total cost. Hazard-classes were re-introduced, and the contributions graded accordingly. Medical benefits have been greatly deflated, while the number of persons covered has risen fourfold in the decade since 1928. And the Soviet health plan has developed into a forceful method of disciplining labor. Cash benefits to adult workers, for instance, are available only at the rate of 50 per cent of their wages after two years of uninterrupted work in the same industrial unit; 60 per cent, 80 per cent and 100 per cent accrue

if they stay three, six and more years, respectively. Motherhood benefits are guaranteed by the Soviet constitution but are paid only to women who have worked at least seven months in the same plant.²

But the aristocracy of Soviet officialdom and labor receive all the sickness care their country is able to give, including richly endowed sanatoria and rest-homes in the Caucasus and the Crimea. And Stalin claims credit for being the Great White Father dispensing health security to all of his subjects.

**MINIMUM OR
MAXIMUM TO
BE PROVIDED?**

After World War II, Western Europe's medical schemes were not revolutionized by open adoption of Lenin's plan. But the latter gave a tremendous impetus in a direction that has been under way ever since Bismarck. The original German set-up was meant to be, to repeat, health "insurance." The weight of the entire scheme rested on cash benefits per day of lost income. Benefits in kind—medical services proper—were supplementary only, largely left to the decision of the individual panel which had a broad autonomy in disposing of the means on hand, even in determining the percentage levy on pay-rolls. The emphasis on cash benefits and on the autonomy of the panels was a basic feature of that original plan wrested from Bismarck by the Parliamentary opposition.

It did not take two decades to reduce to a fraction of the total the share of cash benefits in the disbursements of the German panels. Once services in kind become the mainstay of the sickness scheme, it turns into a queer instrument of wealth redistribution. (All other branches of social insurance, with the partial exception of workmen's compensations for accidents, are restricted to cash disbursements.) Contributions cease to bear any relation whatsoever to the risk involved. Policing by physical controls over a most vital sector of private life takes the place of actuarial calculation.

Thus, the difference between the Bismarckian and the Leninian patterns tends to fade out. But still, the contrast between the old and the new approach reaches into every corner of the problem. Paternalistic as the Bismarckian scheme was, it did not intend to free the individual of all responsibility. He or she was to be secured to the extent only of absolute necessities. An irreducible minimum of health care and of income guaran-

tee was to be dispensed, no more. Accordingly, cash benefits had to be much smaller than the actual income of the recipient when working. Medical services were to offer as much as was objectively necessary to restore health; but the patient was not to be pampered, and his incentive to care for himself and for his family was not to be impaired.

The postulate of economic self-reliance in spite of compulsory "insurance" permeates all medical schemes built on the Bismarckian pattern. The beneficiaries are supposed to carry a major share of the costs by their own contributions and partly also by "deductibles." As to disbursements, they should be kept at a minimum by thrifty administration of the panel and by sharp control over its spending. Otherwise, there is to be no interference with medical practice. In short, business-like management is the *idea* of compulsory insurance proper, presupposing business-like units to do the job in a decentralized, more or less competitive fashion, if under supervision by the authorities.

The latest editions of the Welfare State abandon the misleading claim of offering a system of insurance which would imply some sort of *quid pro quo* between premiums paid and benefits received. In medicine, instead of providing the barest minimum, it promises the desirable maximum. Its objective is to fulfill a social function; the emphasis in lip-service is on what the State allegedly owes its citizens. The security organization is centralized; its administration tends to be fully governmentalized. Ultimately, all medical personnel is to be nationalized, as we shall see.

The Bismarckian type still predominates on the Continent but with profound modifications scarcely expected at the outset. The communistic or state-socialistic principle is not being applied fully except in the East. But the Occidental trend is away from the Insurance schemes toward more streamlined, more totalitarian, Security programs.

HEALTH POLITICS IN BRITAIN

Most instructive is the development in Britain. In 1911 Lloyd George put through his health insurance plan after long and arduous bickering with the interested pressure groups. The resulting panel system was to be strictly "insurance," providing cash benefits with some medical service thrown into the

bargain as an after-thought. It was a compromise that took care of all vested interests except the doctors, who were demoralized by political threats and whose suggestions were ignored. That system operated at the highest administrative cost of all contemporary sickness schemes, an average of as much as 17.4 per cent (in Ireland 20 per cent) of all disbursements, and produced fewer sickness benefits than almost any other scheme. So-called Approved Societies were permitted to offer additional benefits. They were to be run on a non-profit basis and by the insured themselves. They soon became profit-making devices—often nothing but disguised sales pipelines of insurance companies—run by entrenched bureaucracies, whose salesmen were about the only ones wholly satisfied with the system.

The general dissatisfaction with Lloyd George's Health Insurance explains in part the enthusiasm that greeted the Beveridge Plan of cradle-to-grave security. Its *pièce de résistance* was preventive and curative treatment for all of the population. It came at a time when Britain was enamored of the "heroes of Stalingrad," when Communists were the pets of the Allies, and when Churchill indulged in Utopian demagogueries to keep alive the spirits of the British home front. The plan was embraced by a National (coalition) cabinet, headed by Conservatives.³

By adopting the Fabian ideas of Labor, the Conservatives thought to win the 1945 election. Of course, Utopias proclaimed by gentlemen in tuxedos have not the same heart-warming sound as when coming from the lips of old trade unionists with calloused hands. But having committed themselves in advance, the Conservatives could scarcely oppose in 1946 the Bevan legislation founded on their own promotional efforts. For Bevan, in turn, and for the entire Labor regime, the health security project became a vital matter. They could seize the political strongholds which the Approved Societies and other independent organizations represented, including the financial reserves of the endowed hospitals. By 1948, Labor needed a victory on the home front. Harassed by dollar-shortage, austerity policy, industrial strife, mismanaged planning and other misfortunes, the Party staked its electoral future on an experiment that no one else except Lenin had dared before: complete care for all ailments, the best the country could give for everybody, and practically free of charge!

"The genius of bureaucracy consists in copying from other bureaucracies." *Lujo Brentano.*

C H A P T E R F O U R

The Living Schemes: Voluntary and Compulsory

THE IDEA of popular health insurance was nobody's brainchild. Bismarck merely governmentalized the already existing private schemes that originated with the late medieval guilds.¹

A. Free and Semi-Free Panels

THE FREE PANELS From Portugal to Finland, ever since the onslaught of the industrial revolution, workers had banded together in cooperative, autonomous associations of a fraternal character to meet collectively the financial hazards of sickness. They are referred to as the original panels, German *krankenkassen*, French *caisses de maladie*, Dutch *ziekenfondsen*, sickness benefit societies, mutual aid associations, Danish sick clubs, Swedish "orders" and "lodges," etc.² Growing industrialization and urbanization, together with the breaking up of the old guilds, induced men of moderate means, especially those living on day-to-day earnings, to pool their resources. In England the trade unions insured their members against illness long before Lloyd George. In 1909 the purely voluntary Friendly Societies—some of them financially mismanaged due to insufficient supervision—registered 14 million members without being subsidized. Everywhere, cash benefits and/or hospitalization were the mainstay of the movement.

One government after another has put this sort of non-profit organization under supervision and regulation starting with the British Friendly Societies Act of 1793 and a Prussian law of 1794.

Piecemeal local regimentation began, as one might have

expected, in Prussia. In 1845 compulsion was introduced, especially for miners.³ But that did not interfere with the growth of the voluntary *krankenkassen*, many of them offsprings of the trade union movement. They had reached a membership of 869,000, organized in 5,239 panels, before most of them were dissolved by Bismarck under the drastic anti-socialist legislation of 1878. In Austria more than 2,000 flourishing mutual aid societies were governmentalized when compulsion stepped in.

Where medicine is not governmentalized, or partially only, as in Switzerland, Portugal, Sweden, Denmark and Finland, the state supervises these fraternal units. In Switzerland, by 1912, almost 30% of the total population was insured to some degree, mostly for cash benefits only. As of 1949, the Swiss mutuals provide most or all of the needed medical insurance for some 60% of the population. In Denmark about 66% of the people are covered within the framework of quasi-voluntary memberships.

In short, the rational interest of those concerned fosters the spontaneous growth of self-protective organisms, leaving aside the health insurance business of purely commercial character that also has reached a substantial measure of development, especially in Germany. Of course, the system of voluntary cooperatives means different things in different countries, depending on government subsidies and on other circumstances.

DENMARK In Denmark the free associations present (since 1891) the essential features of a compulsory scheme in a setting of apparent freedom. Self-insurance in the Danish sickness clubs—confined to the low income brackets—is being forced gently by limitation of the right to old age and disability pensions to at least “passive” membership in a panel. But the passive member’s obligatory contributions are almost nominal. However, well over one-half of the total cost is carried by subsidies. The state covers most of the medical and dental expenses incurred, including the cost of transportation to the doctor, an important item in an agricultural country. Hospitalization and surgical costs are cared for by the municipalities. The “active” members’ contributions amount, in effect, to not more or even

to less than the cost of cash benefits. In view of the burden incurred by the taxpayer, it should not be surprising that in one essential the Danish system approaches the Russian pattern: it limits the beneficiary's right of choosing his doctor.

SWITZERLAND Another pertinent characteristic of a voluntary system, competition among the panels, is non-existent in Denmark. Her sickness funds are monopolies within their respective geographic boundaries, thus eliminating the competitive incentive for better management, cost saving and better service, that play a substantial role in the complex *krankenkassen* set-up in Switzerland. There, a comparatively mild and partial (cantonal or municipal) compulsory scheme, similar to the Prussian before Bismarck, was introduced in 1918. The system keeps growing. It embraces at present some 2.7 million people out of a total population of scarcely 4.6 million. It is supported by federal and local subsidies, but they amount altogether to barely 20% of panel revenues, to less than the amount disbursed in cash benefits alone.

The federal subsidies are forthcoming under several provisos. The panels must submit periodically to examinations. They must fulfill minimum standards of operation, such as matching special hazards by adequate premiums, accumulating properly invested reserves, re-insuring the tuberculosis risks, charging (10 to 20 per cent) "deductibles" on benefits in kind and guaranteeing the members' right to transfer from one panel to another. They must provide a minimum of services—the floor for cash benefits is an almost negligible one franc (23¢) per day—and they must accept compulsory members allocated to them. This last provision is the least acceptable and financially the most dangerous. But on the whole the economic and social ingredients of the free, voluntary panel systems have been preserved.

Once partial compulsion is established, governmentalization tends to progress—unless it is stopped. It was first rejected in Switzerland in 1899, and then stopped, and this is significant, on May 22, 1949, when a popular referendum crushed by a three-to-one majority the attempt to impose a federal obligatory scheme. After 30 years of experience with varieties of partial compulsion under local administrations, the Swiss people forcefully disavowed their own legislators who were

almost unanimous in attempting to generalize medical compulsion and to put it on a federal footing.

VOLUNTARY PANELS WITHIN COMPULSORY FRAMEWORKS

Private schemes survive in Portugal where the scope of compulsion is limited. So does a particular form of French independent mutuals (*caisses chirurgicales mutuelles*) in spite of the semi-centralization since 1945. Previously, they insured for services not included in the Laval scheme. Now, they cover some 2,000,000 members, people of moderate means, for 40% of surgical costs which is the difference, as a rule, between the actual costs and what the official scheme provides.

Similarly, the Western German independent handicraft and peasantry insure themselves in their own mutual organizations with hundreds of thousands of members.

In England, the working man could take out hospitalization insurance including surgery for himself and his wife in the so-called Hospital Funds. They charged a weekly premium equivalent to a nickel, and less on a monthly or longer schedule. Even the unemployed could afford to pay that much. By 1948 the Hospital Funds counted a total of eleven million members with 25 to 30 million eligible for benefits. Persons with more than \$1,700 income could be insured for hospitalization plus additional benefits at the annual rate of \$7.50. The administration was fairly inexpensive—about 7% of revenues—because its biggest item, the collection of membership fees, was taken care of by voluntary forces.

The English Hospital Funds still retain about 8 million members. Of course, they have had to change their program, since the new (Bevan) scheme offers free hospitalization to everybody. Presently, the largest of the Funds pays weekly cash benefits of about 4 shillings (56¢) for men, 2 shillings for wives, and 1 shilling for each child, for a total weekly premium of 4 pence (5¢) per family, "the cost of a cigarette or two."

SWEDEN HESITATING

One of Europe's oldest voluntary systems is to be scrapped. Sweden's socialist dominated legislature in 1947 adopted a diluted version of the new British sickness security program to nationalize some

1,300 free panels. It was scheduled for July 1, 1950 but has been postponed for a year. It looks, at this writing, as though it will be deferred for another year or two. Lack of sufficient hospital facilities was given as the official reason for the postponement. Possibly, the declining power of the socialist party plays a role, or the Swedes may be watching the outcome of the Bevan experiment.

The case of Sweden is paradoxical indeed. Here is a country that claims the world's lowest death rate. (Is this the case in spite of there being only 4,300 doctors—Europe's best paid—for a population of 7,000,000, or because of that fact? Also, access to medical schools is more limited than anywhere else.) Health conditions are as good as, if not better than, in neighboring Norway, although the latter has "enjoyed" for almost 40 years the fruits of medical compulsion. The Swedish voluntary panels, heavily subsidized since 1935, insure over 50% of the population. They constantly gain new members. A relatively high per capita national income provides most people with the means to take care of their own health problems, by insurance or otherwise, especially in view of a modern, highly subsidized hospital system. Yet they are faced with the prospect of being forced into the compulsory system.

FINLAND That will leave Finland as the only European country without any form of compulsory medicine, but with a low death-rate and a lower than average morbidity of the population. However, not to be overlooked, Finnish public health legislation is very comprehensive, especially maternity care, and, in addition, free hospitalization for the needy is provided.

B. Compulsory Schemes

Compulsion is the keyword in almost every European country's health plan for the masses. The schemes have reached different stages in different countries. Disregarding the infinite number and variety of administrative details, the leading schemes operating west of the Iron Curtain may be classified briefly in three major types.⁴

GERMANY The German system still is the nearest to the original free panel set-up. Membership is compulsory for all wage and salary earners below a certain level of income

(4,500 marks, nominally equal to a little over \$1,000). Spouses and children are insured automatically. For 66 years the payroll taxes which financed the scheme fell on employers and employees in the proportion of one to two. Since June 1, 1949, the ratio has been changed to one to one. Cash benefits, 50% of a so-called "basic" wage, are paid for 26 weeks while medical benefits are forthcoming for as long as "necessary." Special cash benefits accrue for maternity—four weeks before and six after delivery—and for nursing the child, as well as to the family members of the insured in case of his or her inability to work.

The scheme is under a semi-autonomous administration of its own, not under the state managed social insurance set-up, except for the supervisory function of the governmental accident insurance institutions. Their doctors serve as medical counselors to the panels.

A minority of the insured are allocated among 3,400 minor "obligatory" panels of varying sizes organized by professions or by plants. Another 5% voluntarily joined 29 self-constituted mutuals, so-called substitute panels (*ersatzkassen*). The latter are residuals, after a fashion, of the old voluntary units and have about half a million members. But the rank and file are forced into upward of 1,200 local and regional obligatory panels, one for each major town and country district (*orts*—and *landeskrankassen*). All panels enjoy an appreciable degree of autonomy in determining, with governmental consent and up to a limit, the rate of contributions as well as the amount and kinds of services rendered over and above a legally prescribed minimum.

The day-to-day administration of the urban and country panels, which cover almost 65% of all the insured, is in the hands of a permanent bureaucracy that is not part of the regular civil service. Ultimate managerial decisions emanate from boards elected as employer and employee representatives in the ratio of two to one in favor of the latter, i.e., the trade unions.

The German panels are supposed to accumulate reserve funds and used to do so (on and off). The investing of these funds is handled collectively by a governmental agency.

BRITAIN The contrast between German social "insurance" and British (Russian) "security" has been pointed out already. A totally centralized type of organization obtains under the British National Health Service Act of 1946. The panels, which were the backbone of the Lloyd George system, are abolished altogether, and the Minister of Health has all executive power with no appeal from his decisions. Representatives of the professions stand by in an advisory capacity, but the Minister does not even have to publish their reports. Local Executive Councils, 138 in England and Wales, are responsible for the routine of low-level administration and for the policing of the general practitioner, the pharmacies and the ophthalmic services. County and County Borough Councils handle (supposedly) maternity and child welfare, the after-care of the sick, health visiting and home nursing. Responsibility for hospitals, specialists and blood transfusion services rests in England and Wales alone with 146 Local Health Authorities, 14 Regional Hospital Boards, 376 Hospital Management Committees and 36 Boards of Governors of Teaching Hospitals. The latter alone retain a relative measure of legal independence. But the Minister has to confirm all major appointments. Similar arrangements are set up in Scotland.

One outstanding and unique feature of the British scheme is the virtually complete absence of controls—over the patients. Elaborate machinery is available for their complaints against doctors and pharmacies but not for checking their own demands. Dentists have to submit their proposals for appliances to a special board that is supposed to clamp down on "luxuries."

The scheme is part and parcel of the comprehensive social security plan but receives a very small share of the obligatory contributions. Out of the average \$0.95 or so weekly contributions by employees, matched approximately by employers, only about 15 cents is earmarked for the sickness scheme. The bulk of its cost comes out of general tax revenues.

Everyone contributes, with minor differences according to age, sex, etc., and everyone is entitled to the same medical benefits. Both the weekly cash disbursements, which are identical in amount with the "dole" of the unemployed, and the medical services are available without time limitation. The

whole range of services is included—doctors, prescriptions, appliances, treatments, hospitalization — with no strings attached.

Some 3,426 “voluntary” and “teaching” hospitals (clinics) are nationalized, their endowment funds taken over by the government, leaving only Catholic hospitals and private “nursing homes” outside the official orbit. Except in Soviet Russia, medical nationalization nowhere has gone that far—not even in some of the Satellite countries—as yet.

FRANCE In many respects the French scheme of 1945 occupies an intermediate position between the German and the British, especially in matters of administrative organization. The old independent panels have been consolidated into a system of *caisses primaires* (primary panels) which retain a residual of autonomy, although to a much lesser extent than do their German equivalents. They are part of an over-all Social Security organization which constitutes a bureaucratic body of its own — a little state within the state. Their boards are strongly socialist, in part communist, elected as they are, half by the beneficiaries and half by professional groups. The boards have limited managerial influence in the primary panels, within the scope of which falls the care for short and long maladies, maternity, professional sicknesses and the (separately administered) medical care in industrial accidents.

In principle, similarly to the British, the French scheme covers every citizen. In practice it is closer to the German set-up. So far, all employees including the civil servants and the army personnel are covered, but payroll contributions are to be paid from salaries only up to a certain limit. Several classes of semi-independent workers also are forced into the scheme. Farm hands are organized in a separate *securité agricole* under the Ministry of Agriculture, a set-up that runs into great organizational obstacles due to the nature of farm employment and the difficulties of collection and control.

A third basic aspect of the French system is patterned on the Lenin blueprint. All appearance or claim of being an insurance is abandoned. No attempt is being made to accumulate reserves or to equalize risks by special contributions of any

kind. Payroll deductions—roughly two-fifths carried by the beneficiaries themselves—are not proportioned in any way to age, sex, or health conditions. On the other hand, the French system operates in a more business-like fashion than do most others by making an almost general use of “deductibles.” This last point shall be discussed subsequently.

COMPOSITE CONCOCTIONS

The compulsory systems vary in details from country to country. Literally no two countries have the same institutional or administrative arrangements, but all of them include features of the three major types, and borrow their technique from them—usually referring to the concoction as their national specialty. In southern European and Latin American countries the schemes are insufficiently enforced. The *Italian* development deserves to be mentioned, for two reasons. It began with compulsory insurance against tuberculosis only and is being expanded to cover all diseases. And it is the one scheme in which all costs are borne by the employers, another proof of the social-mindedness of its fascist author, the late and unlamented Duce. Mussolini started out as a Marxist and remained a socialist all his life, as shown by the posthumous memoirs of his son-in-law, Count Ciano. Interestingly, an exact copy of Mussolini's noble principle appears in the new medical security scheme of *Satellite Poland*: there, too, the employers have to carry all costs.

The *Belgian* obligatory sickness insurance scheme of 1945 has several peculiarities. It retains, as do *Holland*, *Norway*, *Austria*, etc., the panel system. But the Belgian panels compete with one another not only as “insurance” organizations but also by virtue of political affiliations. They are organized in federations, one each for the socialistic, Catholic, liberal, “neutral” and professional units. Another uncommon method is that of the *bons de cotisation*. At the end of each quarter, the employer hands the employee a certificate stating the latter's wages and payroll deductions. Each panel receives funds according to the number of certificates made out to it. The work and cost of registration or bookkeeping is thus shifted in part onto the employers, and the insured is spared some red tape.

"What worries the conservative is not so much the liberal, as his grandson." Peter Viereck, Conservatism Revisited (Scribners, 1949).

C H A P T E R F I V E

The Dynamics of Compulsory Medicine

THE 1881 Imperial message of Wilhelm I, announcing the compulsory scheme, emphasized that it was the continuation and expansion of traditional poor relief. It was, indeed, just as Lloyd George's project of 1911 was a direct extension of the Poor Law of 1909. In both cases "insurance" was used as the form in which to extend relief. But much more was at stake.

Poor relief on a governmental level was common to all of Western Christianity since the dawn of the Medieval Age. Essentially, it aimed at two things: to provide "full employment," by subsidizing and regimenting business, and to care for the unemployed, including the old, the invalid and the sick, if only in the poor house.¹

POLITICAL EXPLOITATION OF POOR RELIEF

Since the French Revolution, the care for the poor—hospitalization, in particular—became a matter of municipal concern. The intention was to free it from political and bureaucratic shackles and to leave it to the self-governing local bodies. Typically, in 1848, the hospital system of Paris, probably the most modern and comprehensive one of the time, was organized into an autonomous public corporation. What Bismarck did, among other things, amounted not only to revolutionizing the poor relief—by throwing its major financial burden on the shoulders of workers who needed no such relief and on the employers—but also to reversing the process of denationalization. Relief was brought back into the fold of the central power and raised to the high plateau of

national politics. Bismarck's great "discovery" consisted in a device for making political capital out of poverty and human suffering.

Compulsory medical insurance puts a mechanism of its own into motion. So long as the poor are taken care of on a charity basis, some sort of a means-test provides an automatic check. The insurance form eliminates that check and all the inhibitions that go with it. To be sure, it is no insurance at all, since it is not voluntary and is paid by the beneficiary in part only. Nor can it provide any other check implied in genuine insurance, such as the insurer's freedom of choice among the risks and their classification with proper compensation for each specific type of hazard.

But even an impersonal system of subsidies masquerading as insurance offers at least an impediment, for only those can take advantage of it who have an employer to carry part of the premium. Once the principle is accepted that the general taxpayer has to participate in the cost, the basic barrier to expanding the system—from a limited medical insurance to an all-embracing medical security—is scrapped.

HORIZONTAL EXPANSION

Institutions on the political level are subject to the dynamics of the political arena. The first of the inherent laws that rule the life of governmentalized medicine is—that it must expand. It does so, in the first place, by force of the natural increase in membership. But the artificial growth is what matters. It proceeds horizontally, so to speak, by being stretched to embrace more and more people: family members, new occupational categories, higher income brackets. It may be a slow process, as in Germany, where the panel bureaucracy itself resists it, but the ultimate tendency is to absorb the entire population. That stage has been reached in Soviet Russia, so far as the urban population is concerned, in revolutionary tempo since the Czar's modest, and Kerensky's vaguely broadened scheme, while 15 years passed between Laval's panel system to Laroque's generalized (not as yet completed) plan, and 37 years between Lloyd George's and Bevan's. Sweden's voluntary panels are supposed to be nationalized by 1951, and a majority of the population included at once. When Franco decreed medical compulsion in 1942, even the self-employed, up to an

income limit, were included. The final in paradox is attained under Bevan—the millionaire and the wealthy foreign tourists (including scores of lepers from the French African colonies) who do not even pay taxes are subject to the same benevolence as is the domestic pauper.

This horizontal spreading is due in part to a financial motive: to find new contributors or to justify new tax levies to balance the schemes. But almost invariably, financial disappointment results. Family members and *higher income brackets* entering the schemes bring new members with more “refined” medical demands. As a rule, they *cost more in proportion to what they contribute*.

The horizontal growth may be retarded—it virtually never is reversed. It proceeds with a sort of fatalistic necessity—by the inescapable logic of its own political momentum, from wage-earner to the salaried and self-employed, from family heads to the family members, from there to the in-laws (in Czechoslovakia, 1920) and to the housemaids (in Hungary). Austria was the first country to force government employees into its scheme. If people on income up to \$1,000 can get something “cheap,” which is what governmentalization implies, those earning between \$1,000 and \$1,100 naturally ask for it, too, or so does some party seeking their support. The \$1,100 to \$1,200 bracket comes next, and so on, just as in governmental housing.

VERTICAL GROWTH The schemes grow vertically, too. The tendency is, in the long run, to offer more and more cash, commodities and services for lengthened periods at less and less (visible) cost to the recipients. If one kind of medical aid can be provided at somebody else’s expense, why not extend the benefits by including some more kinds? Or stretch it to cover every minor trouble as well, and everything the pharmacies sell? Why not treat the patient for six months instead of two, or for a whole year as in Austria, for three years as in France, or indefinitely as in Germany, Belgium, Britain and Greece? Why not add hospitalization as the Germans did gradually, and the British suddenly? And why not raise simultaneously the cash benefits the patients receive, as Austria did after the first World War and Britain after the second? If the beneficiaries are entitled to medical care at the

price of compulsory contributions amounting to two-thirds of the actual cost, as until recently in the German, Austrian and Luxemburg set-ups, why not reduce their share in the burden to one-half as in most obligatory panel systems, in Germany since middle 1949, or to six-elevenths as in Norway? Or to two-fifths, in France and Greece, to one-third, in Brazil, and pending in Holland, one-fifth, in Peru, and to about one-ninth, in Britain? Why not to zero, as in Italy and Poland, where the employer alone pays? That today is the goal of the Socialist parties in France, Sweden, Germany, Belgium and the Netherlands. Obviously the platform has vote-getting merits. In the meantime, government subsidies are being requested, if not already forthcoming, on top of employer and employee contributions.

A chief motive or excuse for the vertical expansion is the failure of the plans to provide what they promise. In Holland, as an example, a modest amount of dental care is offered within the framework of the obligatory scheme. A little dentistry (free of charge) is sometimes worth less than none at all, patients complain. The appetite is whetted for more, and humanitarians soon take hold of the issue.

GROWTH OF BUREAUCRACIES

The *lateral growth*—by way of broadening the bureaucratic apparatus and adding to it—is irrepressible, too.

As the beneficiaries increase into multi-million figures and the benefits are being diversified, the number of offices and office employees who deal with them must increase accordingly. The sheer volume of paper work necessitates this expansion: registering, filing, bookkeeping, cashing and disbursing, answering oral and written queries, plus checks and controls, internal and external, bureaucratic and medical, etc. Where the patient has to visit the panel first and last, which is the case in most systems, more and more branch offices are opened so as to be at his or her elbow and to avoid too much queuing.

The relation is mutual. The larger the bureaucracy and the more extended its apparatus, the more it tends to strive for additional functions, or at least controls. The ultimate ideal of most administrations, whether French or British, Austrian

or Belgian, is to erect medical centers for the convenience of the consumer, which means lateral expansion as well as vertical. What is more, political and administrative forces drive toward the "consolidation" of small panels into large units, toward centralization and unification. All of which adds up to enlarging the bureaucratic apparatus on the one hand, and to reducing the self-restraints of the membership on the other.

TEMPO OF EXPANSION The surprising fact is that the compulsory systems do not grow by leaps and bounds except when revolutionized, as happened in Russia. Even the recent "eruption" in Britain and France was more apparent than real. It was preceded by several steps of expansion. Extending the benefits to new groups calls each time for legislative action, which slows down the process. But it has become semi-automatic in part, such as by the customary rule of panels that "once a member, always a member"—a rule that permits people who have risen on the social ladder to enjoy the subsidies originally intended for the less fortunate ones. The rule is open to outright abuse—the shop-owner's son registers as a low-pay apprentice and acquires the privileges of life-long membership.

The extension of membership may be put on a voluntary basis. In Holland, since 1945, the self-employed with less than 3,750 florins annual income—now equal to about \$1,000, the same limit as for the employed—were permitted to join, which they did in flocks, raising the membership by about 1,000,000. The same technique has been applied in Germany and in Norway: opening the doors to "voluntary" members, who cannot afford to refuse the subsidy. The voluntary insured constitute about 15% of the total in Germany.

The regular process is, however, to extend the compulsion step by step. In Germany, it went in slow motion from wage-earners (June, 1883) to salaried employees, apprentices, farm hands and to the handicraft employees, through the legislations of 1885, 1886, 1892, 1913, etc. By 1926, under the Weimar Republic, the coverage was generally extended to the family members. From 21.6% of the population in 1910 the number of insured mounted to about 33% in 1939, and to 65% by 1948, the Social Democrats fighting now to broaden

the scope all-around. It went faster in France, starting with miners, sailors and railroad men, then including all wage-earners since 1930. Since 1945, coverage was stretched to include all salaried people, even the top bureaucracy (but premiums are levied only up to about \$1,200 of annual income), then to cover students, the military personnel, farm hands, self-employed truck drivers and redcaps, and so on.

The widening of coverage to more and more people often has little to do with the actual need of the insured. More often, it has political implications. Each move on the road of "medical imperialism" is greeted as the victory of an ideal, and is being sold to labor, in particular, as a step in the direction of "economic democracy."

At any rate, the horizontal diffusion since World War I is nearing its limit, covering (on paper) virtually everybody in Argentina, Australia, Belgium, Brazil, Chile, Eire, Great Britain, Iceland, New Zealand and Spain. Projects on such a comprehensive scale are in the blueprint stage or are hanging legislative fire in France, in the Canadian Province of Alberta, in Sweden and in the United States (Wagner-Murray-Dingell Bill). Elsewhere, the original idea of providing for industrial wage-earners in the low income categories, and only those in regular employment, has been expanded by inclusion of other occupational groups and income brackets. The vertical inflation has not reached its limit as yet. In most countries, all medical services and hospitalization are available to all of the "insured" free of charge, with deductibles applied, as a rule, for major dental and physiotherapeutic procurements only. And where sickness aid ends, disablement benefits step in. But preventive medicine and after-care for the sick still are in the blueprint stage. Italy is the only country to my knowledge that explicitly recognizes the responsibility of the health insurance organization for continuing care for the same sickness after the patient officially has recovered. Such extension in due course may safely be predicted for other countries.

MEDICO-POLITICAL IMPERIALISM

A Welfare State that takes over the provision of homes has a job on its hands. But at least it need not build houses for the same people over and over again, or worry too much about rapidly changing fashions in architecture. In the

field of health care, almost constant changes are indicated by the fantastic progress along every line. Even the mode or fashion of thinking as to the right kind of medical action is in flux. And, contrary to housing, sickness care is essentially still in an experimental stage.

"Medicine is a collection of uncertain prescriptions, the results of which, taken collectively, are more fatal than useful to mankind. Water, air and cleanliness are the chief articles in my pharmacopœia." This remark of an embittered Napoleon on Saint Helena to his doctor, Antommarchi, was out of step even with his own time. But certainly, to our grandfathers, it contained more than a grain of common sense. To them, a "sick" person was essentially one who could not stand on his feet.

The opposite tendency—over-medication—obtains today. Napoleon's dictum may well be compared with the stirring caricature by Dr. Herbert A. Ratner, of Loyola University's Stritch School of Medicine, that calls "nature violated when modern man as the result of medical propaganda goes through life fearing death, expends his health as a hypochondriac, and ends up as a vitamin-taking, antacid-consuming, barbiturate-sedated, aspirin-alleviated, weed-habituated, benzedrine-stimulated, psychosomatically-diseased, surgically despoiled animal. Nature must be shocked that its highest product turns out to be a fatigued, peptic-ulcerated, tense, headachy, nicotineized, over-stimulated, neurotic, tonsilless creature." Jules Romain's comedy, *"Knock, Or the Triumph of Medicine,"* in which a charlatan talks the whole town into various diseases, epitomizes the point that the shining medal of medical progress has a reverse side, too.

What has provided, and provides, a pretext for using the sickness schemes as playgrounds of very expansive (and equally expensive) patronage is the unrelenting advance of medical research in the last fifty years. Indeed, the prophylactic, diagnostic and curative practices all are in a continuous, self-revolutionizing evolution. Once the principle is accepted that the compulsory scheme should provide proper care—what else but the best and latest, and therefore often the most costly, should be provided? So long as a genuine voluntary insurance is in operation, the cost of which is borne by members,

these members have an incentive to keep their demands within bounds. But in the compulsory schemes the individual knows of little or no responsibility for the functioning of the whole. On top of that, politicians and/or bureaucrats have every interest in advertising the schemes by procuring the most spectacular and the most modern services. The doctors, too, have such an interest, especially the young ones who want to make a reputation and to amortize as fast as possible their investment in education, in technical equipment, automobile, etc.

The medical expert tends to be—nay, has to be—“one-sided.” He must devote his time, his energy and even his emotions. He is inclined to look at the world from the point of view of his intellectual and professional goal. The doctor’s ideal is to detect every sickness at the onset, and to “cure” it in the most thorough-going fashion. Sickness is his enemy; to fight it he would mobilize all resources and utilize the best devices. His pecuniary interest drives him in the same direction. This natural and logical expansiveness of the profession tends to grow into imperialistic delusions when the technical tools fall into hands that wield Power. The medical dream becomes the object of exploitation by the ambitious politician. The outcome is something which the taxpayers should be concerned about—and the patients.

SICKNESS— A PATRONAGE GOLD MINE

Once the politician lays his “expert” hand on society’s medical function, the latter must be inflated so as to suit the purpose of the former. Senator Antonelli, a first proponent of social security in France, expressed it graphically while proudly summarizing the “great accomplishment” of 1945: “But one must not forget that *almost everything is yet to be done* in this (medical security) field so as to adjust the medical service to the new institutions. That will be arrived at by *multiplying* the hospitals’ services, the dispensaries, the general clinics of general and specialized medicine, and by preparing and forming technically and morally medical and auxiliary personnel of the new social medicine.”² Mr. Bevan (or Mr. Stalin, for that matter) might as well have written these words which sound like one of his own enthusiastic pronouncements. They reflect the medico-political programs in vogue with the Wel-

farist parties of every color. The ideological source in common is Lenin, of course.

Expand compulsory services must, according to the medico-politicians who use statistics glibly, ingeniously and insidiously. The Surgeon General of the United States Public Health Service (Federal Security Agency) may be quoted as a recent and characteristic example. According to him, of the estimated world population of 2,265,000,000, more than 1,000,000,000 human beings "annually suffer from diseases." Where the Surgeon General obtained these figures or those about the 65% of Egyptians who suffer from schistosomiasis, the 60% to 70% who are afflicted with trachoma, and the 300,000,000 people of Asia, Africa and Europe who are malaria diseased, while one-third of their entire population is syphilitic—remains his secret. But such flimsy statistics, drawn from nowhere, serve as a base from which to claim financial appropriations and to propose vast technico-bureaucratic organizations. They indicate the passion which drives patronage hungry medico-politicians and political doctors, shining but as yet little known stars in the firmament of the Welfare State.

To the vested interests, compulsory medical care is the vehicle of this medical imperialism. Whatever its results may mean to humanity, it means expansion of the schemes in every dimension. So long as they stay within the comparatively narrow confines of the Bismarckian type panels, their wings are clipped; their self-inflating propensity is limited. But they tend to break out of those confines under the double pressure of medico-political ambitions and the public's dissatisfaction with the "incomplete" schemes. Make them complete—is the catchword. It is hard to resist. Depressions, as in the 1930's, may call a halt to, and even reverse the schemes' (horizontal) expansion, only to burst out with rejuvenated vigor in the subsequent boom.

A semi-official but not uncritical French newspaperman, surveying the operation of his country's obligatory set-up and listening to the plans of the scheme-politicians, summed up his impressions by suggesting that the panels should write as a motto on their front doors the words of the fake doctor Knock (in Jules Romain's comedy): "Every healthy person is a sick man who ignores his sickness."³

Skyrocketing Costs

COMPULSORY MEDICINE is in the throes of open and concealed crises. This is true for virtually every single European scheme and is due to unmanageable costs, which in turn hinge on the three dimensional expansion trend.

FINANCIAL NEEDS UNLIMITED

While the medical schemes are new and fresh the difficulties are expected to be smoothed out in due course. Instead, they tend to grow more serious as time passes. The oldest in Germany and Austria have acute troubles to face, as have the latest in Belgium and Britain (and the very latest in this country, Mr. John L. Lewis' own little Welfare State). Remarkable is the similarity of the problems in spite of all differences in national temperament, historical and political background, legislation and administration, personnel and institutions. Whether the plan is drawn up as governmentalized insurance based on payroll taxes levied on employers and employees, as an overall security scheme carried by the general taxpayer, or a compromise form, skyrocketing costs seem to be a curse that cannot be banned unless the doctors are thoroughly curbed and/or the functions of the scheme are profoundly curtailed.

Old age and disablement pensions, death (funeral) benefits, family allocations, accident compensations, even unemployment insurance and cash sickness benefits cover more or less definable, if not always calculable, risks which can be and usu-

ally are limited in financial terms. "Medical care" is an elusive concept. Medicine is a science without scientific—i.e., objective and non-controversial—standards applicable in a mechanical, automatic fashion. Once the principle of necessary health care is accepted and the access to it is opened at little or no charge, the sky is the limit. The deferred time relationship of cost and benefits, the basis of rational insurance, is eliminated. So is all rational risk calculation and risk control, contrary to the practice in commercial insurance.

Distinct from any other field of social security legislation, governmentalized health care means direct intervention by the authorities into a large sector of business activities and private lives. Consequently, subjective judgment enters into the administrative picture at almost every step, opening the door to arbitrary decisions and to bureaucratic red tape and encroachments, to say nothing of conscious and greedy manipulations. A quest for elaborate and costly management and controls arises, of a complexity and an intricacy with no parallel in any other field of social security, pouring its own fuel on the fire of financial troubles.

LLOYD GEORGE, THE BEGINNER In *Great Britain* Lloyd George's National Health Insurance of Bismarckian pattern seemed to keep down costs effectively. Employees with less than £1,700 annual income were "insured." A skilled worker did not receive more than about one-fifth to one-fourth of his wage in the form of cash benefits. No hospitalization had to be provided nor any aid given to the family of the insured. Part of the pharmaceutical costs was deductible. Only about one-half of all insured—depending on the panel to which they belonged—were entitled to dentistry expenses, to which they had to contribute as much as 40 per cent. In the case of eye glasses, 44 per cent was deductible. The scheme was organized in independent and self-administering panels, thus maintaining the principle of competitive incentive.

That scheme, with one-half of the panels' outlay coming out of the worker's pay checks, was stingy as compared with almost any in present-day Western Europe. The more remarkable it is that, even under such circumstances, the per capita

cost of the service doubled in the six years between 1922 and 1927, a period of virtually stable prices.

THE COST OF UNLIMITED SERVICE

Presently, Bevan's "free medicine" to all, even the visiting foreigners, has entered the scene at a jump, accompanied by the greatest drum-beating any scheme has enjoyed since Bismarck's. It started on July 5, 1948, with total cost, including the nationalized hospitals, set at \$800,000,000—at the then valid rate of \$4 to the pound—for the first nine months of operation. By February, 1949, the sights had to be raised to over \$1,100,000,000, well over \$20 per capita of the total population. The Parliamentary debate over the supplementary estimate brought out that the Minister had underestimated in an irresponsible fashion the demand for medical services when available free of charge—or maybe he did so intentionally to overcome the initial resistance against his pet project. In the first year of operation, while the potential patients have just about doubled, from 47 per cent of the population under the old scheme to 95 per cent under the new, the number of prescriptions has almost trebled, and their average cost has risen from over 20 to more than 31 pence.¹ Compared with the annual demand previous to July 1948, the number of eye glasses requested has risen four-fold. The number of people appealing for dental care has grown suddenly from 8 per cent of those entitled under the old scheme to 20 per cent under the new. The unit cost of ophthalmic, dental and hospital services went up spectacularly, too. At a time when commodity prices were practically stabilized, the price of a pair of spectacles was found to have risen by 50 per cent, from 40-45 shillings to 65 shillings 6 pence, while the weekly hospital ward rates jumped from 4 pounds per bed to 8 pounds, 10 pounds, and more.

For fiscal 1949-50, \$1,410,000,000 is the budgeted cost of the new health scheme, just about 75 per cent more than what the brilliant Minister had figured nine months earlier, and a good third over what the Beveridge Plan estimated—for 1955. There is no sign so far that the cost curve will flatten out, to say nothing of descending, in spite of some cuts such as in dentists' honoraria and in the capital budgets of the hospitals, unless the system is deflated. Actually a supplementary \$4

millions for dental care had to be granted only three months after passage of the 1949-50 budget. On the other hand, if the scheme should be carried on along its present lines, both the general practitioners and the specialists are expected to get raises, and the vastly increased demand for hospitalization will necessitate huge investments. At this writing there is little doubt left that another good-sized supplemental estimate will have to be presented to Parliament before the current fiscal year is over. And that is not the end of it.

The new British health scheme is so constructed that a great many expenses do not appear in the budget. In England and Wales alone, the local administrative agencies employ more than 30,000 salaried clerks, but under the actual management of approximately 10,000 unpaid voluntary workers. A very large share of the routine is taken care of by the general and dental practitioners, who are not paid for this extra function. Thanks to such unpaid services, voluntary and forced, the administrative cost—not counting hospital administrations—so far has been kept down to about 4 per cent of the total outlay, which is probably the lowest managerial cost ratio of any European scheme. But this “economy” is more apparent than real, as we shall see.

FRANCE: OPEN AND HIDDEN SUBSIDIES

Different as the French scheme is from the British, it is confronted with the same financial “trap.” It is being financed by pay-roll deductions, partly at the worker’s expense, amounting to:

- 2.80% in 1938—under the old panel system;
- 4.80% in 1946—first year of the new scheme;
- 5.44% in 1947, and
- 6.16% in 1948.

But the more than doubling of forced contributions is not enough. In 1948, the scheme—not including farm labor that comes under the *securité agricole* and has its own worries—ran a 10 per cent deficit over and above the 6.16 per cent imposed upon every paycheck up to an annual income of nominally about \$1,200.

To appreciate the full significance of this financial weakness one must realize that a large slice of the costs, and a growing one at that, is being shifted onto other shoulders. The scheme is supported by hidden subsidies. One of them is paid in effect by the beneficiaries themselves, who are supposed to assume 20 per cent of the cost of medical, pharmaceutical and hospital service, except in the case of maternity and of *longue maladie*. In reality, so far as doctors' honoraria are concerned, the patients pay much more than 20 per cent. Another source of hidden subsidies is the contributions to the cost of hospitalization by local authorities and charitable organizations. Furthermore, large firms subsidize the nationalized health program by taking over a great deal of its paper functions at their own expense. Part of the administrative and bookkeeping work of collecting, checking and reimbursing on sick tickets is being taken care of by the employers. Business has to assume responsibility for the first 30 days of sick pay of white collar employees. Also, every major firm maintains a more or less fully equipped infirmary, and has to retain the services of a doctor who facilitates the control work of the scheme.

To cite the many ways in which the operating cost of the French system, as of others, outruns the official "visible" data would tax the reader's patience. To mention one or two more: hospital patients, ambulatory and hospitalized, enjoy the services of outstanding French specialists at nominal fees. A large slice of the cost of medical service to the scheme patient is thus shifted onto the private patients, if not onto the doctors. And the national "preventive" health policy is financed largely by a separate Ministry of Health at no cost to the panels.

Despite all this unbudgeted and unadvertised subsidy thrown into the bargain, the French scheme runs a deficit year after year. The administration (Ministry of Labor) consoled itself until recently by blaming it on the inflation. But the 30-fold inflation of retail prices from 1935 to the end of 1948, or even the 35-fold rise of the less relevant wholesale index, can scarcely explain a nearly 70-fold rise of total costs (not counting the hidden subsidies), not even if the extension of coverage to about 20 per cent more persons is taken into account. Costs were upward bound before the war-time and post-war inflation occurred and they are rising after the price inflation has

slowed down to a trickle. The 1948 average monthly outlay amounted to 4,602,000,000 francs. In 1949, the *assurance maladie* spent:²

5,323,000,000 frs. in January;
6,439,000,000 frs. in February, and
7,146,000,000 frs. in March.

Between late 1948 and the middle of 1949, the official French price index receded by 5 per cent, but the medical scheme produced fresh "visible" deficits. They are being covered by recourse to the reserves which the sickness panels of the Laval scheme (called *caisses de répartition*) accumulated prior to 1945—before the comparatively restrained and decentralized Bismarckian type of Social Insurance was widened into an ambitious Social Security à la Lenin.

FALLACY OF SELF-SUPPORTING COMPULSION

This is the system which the French Administration proudly boasts as being "self-supporting." The claim is fallacious, even if its hidden subsidies and the technique of camouflaging its deficiencies—by eating up its own reserves—were disregarded. It is highly misleading to use a terminology that conveys the false appearance of financial self-reliance wherever the cost of a scheme comes out of payroll taxes "only." As if levying a payroll tax on the employer would not be just as much of a tax—one that almost invariably is shifted on the consumer!—as is the raising of revenues by income taxes and excises! As if subsidizing the beneficiaries at the expense of their employers would be any different in nature from subsidizing out of the general taxpayer's pocket!

By the way, the governmentalized "insurance" plans inherited the tradition of their predecessors, the free panels, and used to build up *reserves* equivalent to at least one year's expenditures. The idea was to protect the organizations against the impact of epidemics or other emergencies. The new, comprehensive security schemes have abandoned the pretense of financial self-reliance by scrapping this policy of reserve accumulation. They live from hand to mouth, relying on the taxpayer.

PROGRESSION OF FRENCH ILLNESS

A few "coefficients" may suffice to show where the financial trouble in the French scheme lies. Taking into consideration that the number of persons "insured" has risen since 1938 from 7 million to 8½ million, this is the picture, in index numbers, of per member expenditures by major categories, 1938 as base:

	1938	1947	1948
Medical expenses per member.....	100	1,920	3,400
Surgical expenses per member.....	100	2,400	4,000
Pharmaceutical expenses per member	100	1,520	2,880
Dentistry per member.....	100	5,120	9,600
Hospitalization per member.....	100	2,400	4,800
Cash benefits per member.....	100		3,600
Index of doctors' fees (paid by the panels).....	100		1,100
Index of surgeons' fees.....	100		750
Index of pharmaceutical prices.....	100		1,500

It should be clear at once why a 2¼-fold increase of contributions on a 20-fold augmented payroll is needed. The largest rise occurred in the per capita dentistry costs—just as in Britain under Bevan. Note that in the French system these costs still keep rising; the urge for new teeth does not seem to quiet down.

Or take the medical expenses. Doctors' honoraria, which the panels refund, have risen in a decade about 11-fold. But the per capita medical expenses of the scheme jumped 34-fold. Obviously, people go to the doctor three times more often—per insured, mind you—than they used to under the previous, more limited panel system.

Less exciting is the rise in pharmaceutical costs per insured, due to the fact that prices are controlled. Even so, a 15-fold rise of the latter contrasts with a 29-fold increase of the former.

The index of surgeons' fees (paid by the panels) has risen barely 8-fold. But average surgical expenses went up 40-fold. Could it be that the average Frenchman goes under the knife five times more often than before?

This fantastic expansion of services may be due in part to a larger number of dependents about whom no statistics are available. But even if the 1½ million additional members

have more children each than the previous 7 millions, that could not account for the difference, still less for the vast increase of disbursements in the single year 1948, which was substantially greater than in proportion to the price inflation of that year. One of three explanations is feasible: either the compulsory system is a failure (instead of curing people, it makes them sicker); the new members brought in belong to "higher" classes of society which demand more than the average amount of medical service; or the services may be misused under one pretext or another by malingerers and cheaters.

One spiraling cost element certainly has nothing to do with the size of families. I am referring to the 36-fold rise, in ten years, of cash benefits per insured. After a waiting period of three days—thirty days for white collar employees—the insured Frenchman receives a half-pay indemnity for lost income, and 66.66 per cent after 29 days. On the average, wages have risen 20-fold. That leaves a huge residual of unexplained rise in paid-for per capita sickness days. Something must be basically wrong with the scheme.

COST OF

BUREAUCRACY . . .

The health schemes' administrative costs account for as much as four-fifths to five-sixths of the managerial overhead of the respective countries' total social security management.

Within the health schemes, the bureaucracy absorbs "normally" around 8 per cent of total outlay, which is appreciably higher than in commercial health insurance, disregarding the expenses of the latter on advertising and on customer solicitation. However, generally speaking, the managerial cost is higher in centralized schemes and in large units than in decentralized systems and in smaller panels. This seems to be contradicted by the fact that the lowest cost ratio obtains in Britain. The Bevan plan, the most centralized one next to the Russian, manages to get along on less than 4 per cent administrative costs. But its outlays per capita are so much higher than in any other scheme that the comparison loses validity. Since socialized medicine costs "austere" Britain per beneficiary roughly three times what the French pay out—and about 50 per cent more than the panels of rich Switzerland disburse at present, or those of a prosperous Nazi Germany did before the last War—the

4 per cent cost ratio is in fact equivalent to one of about 8 per cent. Besides, the British plan shifts a higher share of the administrative burden onto the doctors and voluntary administrators than does any other. Also, it keeps its managerial cost down by omitting the customary controls. Thereby it permits the medical benefits to skyrocket without even the modest limitations applied on the Continent.

... AND OF
POLITICAL
CORRUPTION

As scheme bureaucracies go, the French probably is Europe's costliest at present. Some primary panels' administrative costs run as high as 20 per cent of their total outlay, with an average ratio around 12 per cent. One reason for this high cost is the centralized system which eliminates competition between panels and the incentive to low cost operation. In fact, the French panels are not responsible to their members, and it makes no difference how extravagantly they operate. The excessive costs of one panel are covered by the surpluses of others, thereby in effect penalizing good management. This holds for the Belgian system as well. And the French bureaucratic set-up is exposed to political corruption as perhaps is no other, unless the Spanish and the Portuguese. It is over-staffed with personnel put in by the political parties and the trade unions. It does not permit economies by dismissal of the inefficient. The primary panels, the organs of the sickness security, counted 16,000 payrollers at the end of 1946 and well over 25,000 by early 1949. They grow at a faster rate than does the number of insured. This unrelenting "lateral" growth is typical of a centralized system in which the impetus of expansion emanates from "above."

In France, 80 to 85 per cent of the administrative cost is paid out in salaries and wages. But the capital expansion cost is by no means negligible. Visiting a workman's suburb of Paris one is struck with the unrelieved monotony and decay present—gray, dilapidated, dank housing facilities, the lot of proletarian existence. One building, however, stands out in the midst of this desolation, like an angel's statue in a cemetery of decaying tombstones. It is the brand new, clean, shining white, modernistic structure of the local panel's branch office. The scheme administration plans an office for every 2,000 clients, to bring its function to their doorsteps as does

the post office. At mid-1946, Paris had 30 branches. There were 140 at the beginning of 1949, and new ones are under way. But the post office is satisfied with simple surroundings. Yet the most remote branch of the sickness scheme needs a building of its own, with spacious waiting rooms, modern medical installations, and attractive offices for the distinguished precinct politician in charge. Panel constructions are a rich source of orders to contractors and suppliers of proper political orientation. Similar capital expansion in the earlier days by the German and Austrian panels had been greatly criticized in the respective countries.

One more remark about average administrative costs. Their long-run trend in most countries is either a slow rise or a remarkable steadiness in terms of percentage of total expenditures. But with rising total disbursements, the administrative expenses should decline percentage-wise. The fact that (outside Switzerland) these costs parallel or even outrun the increase in spending indicates one of two things: either the bureaucratic apparatuses keep expanding unnecessarily or their attempts at control increase costs to an amount greater than is saved by the efforts. At any rate, in both the French and the British systems the bureaucrats actually outnumber the doctors working for the respective schemes. A witty French journalist quipped that "more nurses and less secretaries" should be the administrative device of his country's sickness plan. Incidentally, in France as almost everywhere else, the salaries scheme officials pay themselves are far more generous than the rates they are willing to concede to the practitioners working for the scheme.

Financial Insecurity of Health Security

COMPULSORY METHODS of providing medical care tend to unbalance the accounts of the sickness panels. People forced to join a cooperative or to pay contributions to a governmental scheme share no responsibility for, and take little or no interest in, its welfare. They exploit it accordingly. This is visible even in the Swiss scheme which, among all those under some sort of state control, is the most successful. It is burdened with the least amount of authoritarian rule and uses the smallest share of "other people's money."¹

FINANCIAL TROUBLES EVEN IN SWITZERLAND

In Switzerland, as has been mentioned, no medical compulsion is being exerted by the national government itself. It pays, however, moderate subsidies—an annual \$0.75 to \$1.00 per insured, with extras for maternity and tuberculosis cases—to "recognized" and supervised panels which have to provide a defined minimum of services. Since 1918, the *cantons* may apply compulsion either directly or through local authorities, keeping it within specific income limitations, and always under the spelled-out clause that employers cannot be forced to contribute.

The result is that the map of Switzerland, shaded according to types of health insurance compulsion, or lack of it, looks like a checker-board. By and large, only industrial cantons or cities, and those up in the high mountains, take advantage of the power vested in them. In some, industrial workers have to be

insured; in others, only school children, or all children. Here, the entire canton is covered; there, only some of the cities or counties. Where compulsion is applied, the canton and the municipalities contribute to the costs but very moderately only.

In spite of vast differences between individual units, and with an appreciable income from invested funds, the Swiss panels rely on aid from federal and local authorities. Virtually every year, the system as a whole runs an operating deficit of about 18%. It is being covered by subsidies amounting to roughly 20% of total expenditures. With all that, the battle against further deficits is the prime worry of all concerned.

In the middle 1930's the *konkordat* (re-insurance federation to cover the special risk of tuberculosis cases) of the German-Swiss panels sponsored a study of their rising costs. It revealed that annual per-member disbursements of the largest "private" panel increased from 22.51 Swiss frs. (\$5.25) in 1910 to 31.94 frs. (\$7.50) in 1925. After a modest decline during the great depression it still stood at 27.21 frs. in 1934 and jumped to 30.92 frs. in the following year. In a major cantonal ("public") panel the per capita cost rose from 15.88 frs. in 1910 to 28.18 in 1925 and to 35.19 in 1932, right in the midst of the depression. It reached 35.93 by 1935. In every instance, it has been rising under conditions of the war-time and post-war boom. If depression cannot stop the growth of expenditures, inflation certainly helps to bolster them. By 1947 the per-member expenditure of the average Swiss panel climbed to almost 70 frs. (\$16.40) per annum, nearly double the level of the late 1930's.

COST PARING BY MORBIDITY CONTROL

By the late 1930's the Swiss panels instituted a great many reductions in medical service, thereby checking the rise of costs and keeping it within the limits of commodity price increases. Table I shows the very slow rise, or actual decline, over the last decade, of morbidity in those panels; this in spite of the steadily growing percentage of women in the total membership. Note that the Swiss statistics strictly distinguish between the operations of two kinds of insurance: for cash benefits and for medico-pharmaceutical services. (The latter do not include dental services, the amount of which varies

greatly from panel to panel.) Members may contract for one of the two kinds of insurance, or for both, as the majority does.

TABLE I

	<u>1938</u>	<u>1943</u>	<u>1944</u>	<u>1947</u>
A. Cash Benefit Insurance:				
Number of sickness (absentee) days per 100 insured				
Male	860	840	800	870
Female	1,000	890	840	930
Average length (days) of sickness				
Male	29.5	29.1	23.1	24.6
Female	35.3	28.6	24.7	28.4
B. Medical Service Insurance:				
Total medico-pharmaceutical costs in Swiss francs				
Per Male	25.97	29.83	33.58	39.70
Per Female	38.40	45.73	48.34	59.06
Number of hospitalization days				
Per 100 Male	160.9	245.6	171.9	180.0
Per 100 Female	158.4	234.0	251.4	260.0
Number of sick per 100 insured	53.5	64.1	65.4	63.9
Number of sickness cases per 100 sick	137.5	131.9	142.3	141.4

The trouble is that per-member outlays grow, and ever-fresh problems of financing arise. Premiums for cash benefits, levied in percentage of wages, have remained fairly constant. But the rates charged for medical and hospitalization insurance have more than doubled since 1911. However, each "upping" creates resistance among the membership that carries the cost. As a rule, it prefers to get less rather than to pay more. Therefore, since the middle 1930's, the Swiss panels have imposed on their members cost-paring rules, such as lengthening the waiting periods, reducing the scope of the services rendered and raising the "deductibles."

This self-deflating propensity of the comparatively free panel—free from political interference—is one distinguishing feature. For another, administrative expenses are under control, too. They average about 8.5% of total costs, running as low

as 4% in small units and plant panels. But the growing concentration in large units with numerous branches brings with it a tendency toward unwieldy bureaucratism. Also, the unhealthy practice of under-insuring for cash benefits has become almost generally accepted. And major panels are increasingly burdened by involuntary members who are being "allocated" to them and who tend to exploit the respective organizations.

GERMAN FIGURES TELL THE STORY

The long history of German compulsory medicine is a mine of information. It started with a 4½% payroll tax, two-thirds of it charged to the workers. Presently, 7 to 7½% is the rate in most panels, and the socialist party fights for raising it as well as for shifting the entire burden on the entrepreneurs.

The increase of per-member expenditures in the German panels was comparatively slow until about 1914. Even so, outlay per insured trebled in the first 30 years. Then, an accelerated horizontal and vertical expansion set in with results shown in the following tabulation of average *per member* expenses (in gold marks):

TABLE II

	Doctors	Dentists	Pharmacies	Hospitals	Cash Benefits
1885	2.15	—	1.69	1.01	5.37
1900	3.60	—	2.73	2.06	7.35
1913	6.92	—	4.45	4.34	11.91
1925	13.24	2.35	7.32	8.24	23.03
1930	19.32	4.15	10.14	13.78	25.04

Why this rapid and almost continuous increase in total per capita medical expenditures—from 10.22 marks (\$2.50) 45 years ago to 27.62 marks (\$6.60) in 1913, and 72.43 marks, almost \$18.00, in 1930? The general price level alone could not be blamed: it rose in the whole period a bare 50%, mainly after 1913.² By then, the panels already had expanded their services to 4 million dependents, which number grew to 15 millions in 1928. But that does not explain the per capita cost inflation. Dependents were not being cared for as liberally as were the insured. The latter themselves had been the chief factor, as shown by the column "cash benefits" in Table II.

The panels had been extending more and more privileges to their members who in turn were taking more and more advantage of those privileges. During the 50 years under review, the rate of remuneration of German doctors working for the panels had risen very little. Evidently, if medical costs went up as they did, it was because the patients were patronizing the physicians with growing frequency. Most spectacular was the sky-rocketing cost of hospitalization. Dentistry was a late comer on the schedule of German panels: small wonder that its cost rose 7-fold in the 1920's. It was the era of the welfarist Weimar Republic that was spending freely for municipal improvements and swimming pools as well as for medical benefits. "Corruption" in social insurance—in sickness care as well as in accident insurance—had become something of a national scandal which culminated in 1928 and helped to undermine the Weimar Republic's domestic prestige.

When the "borrowed prosperity" came tumbling down, the sickness scheme had to undergo a thorough house-cleaning. The Nazis took over a deflated scheme in a deflated economy. The panels were at first in Hitler's "doghouse." But the rearmament boom reconciled labor to the Third Reich. Full employment raised the membership by millions, and the vertical expansion of the medical system was resumed, too, as indicated (Table III) by a 22 per cent increase of per-member expenditures in five years' time.

TABLE III

	1933	1938
Number of panels.....	6,427	4,524
Number of insured (without dependents).....	18,540,000	23,222,000
Revenues (in marks).....	1,581,744,000	1,802,617,000
Total expenditures (in marks)	1,180,876,000	1,781,485,000
Administrative expenditures (in marks).....	127,860,000	160,805,000
Surplus of revenues over expenses (in marks).....	400,868,000	21,132,000
Total costs per insured (in marks).....	63.67	76.71

This huge growth in the number of contributors boosted the revenues of the panels accordingly. But since 1935 their costs were rising even faster, in spite of the control efforts of the Nazis. The substantial surplus of revenues in 1933, which reflected Brüning's incisive cuts in costs, was reduced in 1938 to a negligible amount. In reality, the panel system was operating at a loss, the deficit being covered by the liquidation of assets accumulated in better days. The financial deterioration became progressive again. By 1938, the Nazis solved the problem—by stopping the publication of detailed figures on panel costs and finances.

MORBIDITY AND ABSENTEEISM

Let us turn back once more to the panel costs in pre-Nazi Germany (Table II, p. 65). "Cash benefits" is the most revealing single item. German wage rates in 1930 could have been scarcely more than double, if that, those of the late 19th Century level. The amount of per-insured cash benefits—60 per cent of wages, plus very minor family allowances—could not have been appreciably affected by the number of dependents. Yet per capita cash benefits have trebled. Obviously, the average German worker was acquiring the habit of taking sick leaves. The shortening of working hours since the 1918 revolution had the effect, if any, of strengthening that habit.

About one-third of all insured were absentee-sick, for an average of eighteen days each, every year prior to World War I. Absenteeism reached its peak in 1928: every second insured taking leave for an average of twenty-four days each! This long-run trend of growing morbidity was not due, as one might surmise, to women entering the panels in increasing numbers. Their morbidity "coefficient" is slightly higher, but it did not rise appreciably faster than that of the male insured.

Anyhow, Brüning's deflation reversed the "secular" trend of growing absenteeism—for a while, as indicated by the data of Table IV.

TABLE IV
Sickness Statistics of German Obligatory Panels.

	Number of Sickness (absentee) cases per 100 members	Number of paid sickness (absentee) days per sickness case with inability to work	Number of paid sickness days (with inability to work) per 100 members
1885-1913	37.8	18.1	685.2
1913	42.1	20.6	867.6
1925	51.5	24.4	1,256.2
1928	55.4	24.0	1,329.8
	* * * * *		
1933	36.1	25.6	924.9
1937	41.6	22.6	936.7
1938	45.7	21.7	991.7

In one respect, at least, the Nazi regime turned out to be a blessing in disguise. It stopped the scheme's rapid "lateral" expansion that had been going on for decades. Administrative expenses for personnel in the metropolitan *kassen* had risen 6-fold between 1890 and 1930. Under Hitler's feverish armament program German manhood found more glamorous occupations than the panel bureaucracies could offer with practically frozen salaries in exchange for much work and little prestige.

COST PROBLEMS OF LITTLE COUNTRIES Many of the smaller schemes suffer from the same type of financial pains as do the larger ones. In *Belgium*, the sickness panels, numbering well over 1,000, were put, in 1945, into a compulsory system.³ They are subsidized by the State to the tune of 16% of contributions. But by 1948, an additional overall deficit—a "visible" one—of 1,000,000,000 francs (about \$20 million) had to be taken over by Parliament. It balks in 1949 at repeating the performance. An ordinance of January, 1949, compels the Belgian panels to cover their losses retroactively by raising the amount of contributions at the end of each year in which they run a deficit. Presently, Belgium struggles with the problem of reorganizing the whole scheme.

Take the current situation of the *Austrian* scheme. The panels were in the black and even accumulated surpluses during the famine and inflation years immediately after the war, including 1947. But they became infected by the expansion-urge and went a long way in constructing ambulatoriums and polyclinical facilities. As soon as the monetary stabilization cut off the easy flow of funds and brought in a new flow of patients, the surpluses turned into a 15% deficit. The government had to step in with subsidies.

Numerous compulsory schemes operate without open deficits. But most of them are subsidized at the expense of national and local budgets in addition to employers' and employees' contributions. Also, every single scheme draws hidden subsidies—from the doctors. Even so, not one of them can live within its own budgeted revenues unless by greatly restricting the services it is supposed to provide. Practically none of the governmentalized plans is any longer in the habit of accumulating financial reserves, as the German panels did in better days.

THE BURDEN OF SOCIAL SECURITY Western Europe's economy is stymied by over-expanded social security burdens on top of a record high level of general taxation. The tree of the Welfare State is in full bloom. French social security taxes of all kinds paid by business, including the cost of paid vacations, are estimated officially to average 34.5% of the payrolls, two-fifths of them for the sickness and maternity scheme. But the metal industry of Paris carries a total of 44.7%, not counting the voluntary welfare expenditures of the firms, as against 15% in 1938. The social security cost of the government-owned railroads has climbed to well over 50% of their payrolls; one major nationalized insurance company claims to be loaded with 82%. The comparable payroll taxes charged to employers were in 1947: 18.2% in the Netherlands, 23.6% in Belgium, 20.5% in Luxemburg, and an estimated 18 to 20% for Trizonal Germany, etc. In each case, the employees pay additionally (6% in France, 7.65% in Belgium), often shifting these taxes, too, on the employers. The load on payrolls is growing. In Belgium, as an example, since the middle of 1948 it amounts to 29.53% to employers and 8% to employees. All this is on top of over-inflated, budgeted taxes. Of

total budgetary revenues as much as 25% to 35% also serve for "social" subsidies and similar expenditures.

Nor is this trend restricted to socialist-ruled countries. Governments to the right, as in Italy, compete with the left in social spending. Peron's semi-fascist regime leads the world-wide race in generosity, with an average 60% of the wage bill loaded on Argentina's industry.

The provision of health care is the most unruly—least controllable—element in public spending for the "security" of the individual, leaving aside the fact that virtually everywhere the sickness schemes are bolstered by charity and voluntary, unpaid efforts. Significantly, and obviously referring to the Bevan scheme, Sir Stafford Cripps found it necessary to warn his own Party in his last (1949) budget day message:

"We have to face our economic and financial problems with realism, and must not allow ourselves to be carried away by the quite understandable desire to court electoral popularity. When I hear people speaking of reducing taxation and at the same time see the cost of Social Services rising rapidly, very often in response to the demands of the same people, I wonder whether they appreciate to the full the old adage—we cannot have our cake and eat it. We must recognize the unpleasant fact that these services must be paid for and they must be paid for by taxation, direct or indirect . . . There is not much further immediate possibility of the redistribution of the national income by way of taxation in this country . . . We must, therefore, moderate the speed of our advance in the extended application of the existing Social Services to our progressive ability to pay for them by an increase in our national income. Otherwise, we shall not be able to avoid encroaching, to an intolerable extent, upon the liberty of spending by the private individual for his own purposes."

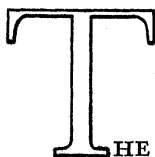
DEFLATION IS POLITICAL SUICIDE

It is with this background of overstrained Welfare or Service States in mind—that comprises also a multitude of social subsidies for food, housing, transport, and fuel, plus aid to farmers and veterans and for reconstruction and nationalization, etc.—that the problem of rising costs in the compulsory health schemes must be visualized. Commercial insur-

ance can raise its premiums and lower its services to maintain its balance. Compulsory systems scarcely can go back on the services they once have established. Some one would be risking political suicide. Semi-dictatorial regimes, caught in a depression, like Brüning's in Germany (1930-31) and Schuschnigg's in Austria (1937) tried it. That helped to seal their fates. Only a military ruler like Pilsudski in Poland (1933), and, of course, Stalin (1938) can afford such experimentation.

The abolishment altogether of a compulsory sickness scheme, once established, even if bankrupt and unsatisfactory, is beyond imagination. It never has happened. The difficulty of raising additional contributions and subsidies puts the schemes in a tight spot, an ever-tightening one. It necessitates economies, which in turn negate the very purpose of the schemes. Invariably, the doctors are the first victims in this conflict between political objectives and financial realities.

A Medical Proletariat



HE doctors are, of course, the key figures of governmentalized medicine. The prime purpose is to procure their services and all that goes with them. Their honoraria alone, disregarding the dentists', constitute anywhere between nearly 50 per cent (in Switzerland) and little more than 15 per cent (in Britain) of the total cost. But far more is at stake. Being the focal point of medical procedures, the doctor directs the course. He decides who is sick and for how long, and thereby determines the trend of cash benefits, the quality and quantity of pharmaceutical products, the need for hospitalization, X-ray, laboratory and hydrotherapeutical services, etc. Even the cost of administration is dependent in part upon the degree of control over the profession. And what is more important than all cost problems—the welfare of the patient is in the doctor's hands.

Governmentalized health services sooner or later run into the iron curtain of mountainous costs. The easiest way out is to curtail honoraria, denouncing the doctors as profiteers. That may or may not be true, but it is both popular and money saving.

GERMAN DOCTORS' MISCALCULATION

There was no serious medical opposition to Bismarck's sickness insurance when it went into operation in 1884. Indeed, the profession was gratified. Legally it still was a *gewerbe* like any other, different from barbers in degree of education but subject to police regulations, especially to a tariff with minimum and maximum rates. Governmentaliza-

tion raised the social level of the profession by bringing it almost to the dizzy height of civil service status. Also, new vistas of financial and scientific progress seemed to open. The radius of health care was to extend on a broad front, medical studies to receive a great impetus and encouragement.

Be it out of enthusiasm for the new idea or out of sheer subordination to the almighty Prussian bureaucracy, if not out of greed, the German doctors gave away their birthright and that of their patients from the outset. They did not stand on the principle of professional secrecy, but tolerated from the very beginning the rule of panel employees over professional decisions. And they agreed on being paid by the panels rather than directly by the patients. When they recognized the consequences it was too late.

At first the panels experimented with engaging physicians as poorly paid employees. This method had to be abandoned due to the general malcontent and to the airing of corrupt practices—selling of jobs to doctors.¹ The next step was to establish the free choice of the doctor by the patient, but only among doctors who entered into contractual relations with the individual panel. Any of them could do that. Otherwise medical practice was to be the same as in private, except that the fee was controlled by contract on the basis of medical performances, the so-called *attendance system*. Naturally, the number of performances mounted as it did under the same provision of the Lloyd George system and tends to do under similar arrangements even in Switzerland. The *kassen* retaliated by cutting the fees. The lower the fees, the greater was the incentive for the doctors to raise the number of attendances. The war was on.

To squeeze the doctors' fees at each contract renewal became a major job of the panels. They were at great advantage in dealing with individual physicians. The latter organized a fighting trade union, the Hartmann Federation, in 1900. Collective bargaining—the very first in Germany—was to replace individual contracts. A further purpose of the Federation was to take out of the hands of panel administrators the arbitrary power of accrediting panel doctors. Free competition among physicians was to be restored.

DOCTORS vs. MONOPOLY But that was just the beginning of the real battle. By 1913, after a prolonged exchange of threats of strike, lock-out, boycott, etc., between the Hartmann Federation and the panels' association, the "Berlin agreement" was concluded. From then on, the number of accredited practitioners was to be limited, such as to one general practitioner per 1,000 to 1,350 insured, and similarly, specialists. The patient could choose among panel doctors only. These were organized in a separate federation, the number one function of which became to regulate by red tape the accrediting of panel doctors—to block newcomers. The panels, too, insisted on restricting free competition: more doctors mean more patients.

The bulk of the profession itself was broken up into three classes with antagonistic interests: the so-called panel doctors, eligible to the insured, many of them retaining their private practice; the "trustee" doctors employed in a supervisory capacity; and the rest who practiced in private only and as occasional consultants of the panels. This last group of physicians was largely responsible for the once renowned medical progress in Germany. Friction among these medical groups has become a standing feature of the system, in addition to the class warfare between the association of panels and the federation of panel doctors.

Having become quasi-monopolists—a role doctors do not deign to assume—did not make the panel doctors any happier. Their incomes kept declining while the abuses were rising.²

The Great Depression was the proverbial "last straw." It ruined the doctors' bargaining position and opened the door for a radical reform. That was imposed finally by Brüning's emergency decrees, especially the one of December 8, 1931. He was running the Reich by emergency decrees as a "constitutional dictator," unwittingly preparing the ground for the real one. The main feature of the new system was a quarterly capitation fee that was to set the pattern for Holland, Britain, etc. It had been applied by individual panels before, but became mandatory with the Brüning reform and still is in force.

The total capitation fee (*pauschal-betrag*) for all accredited doctors is being figured out by way of a complicated formula, based on the number of insured and the sum of contributions

collected by each panel, and on a number of minor factors. Presently, approximately 20 per cent of panel revenues is paid per quarter to each panel doctors' federation that distributes the money among its members. Fees of specialists and for special services are deducted first together with contributions to a pension fund for the panel doctors (who are forced into early retirement) and a 2 per cent charge for the federation's own expenses. The rest is divided among the practitioners, which means to them never more, and often less, than a quarterly 4.20 marks per patient—the equivalent, before the Roosevelt devaluation, of about \$1.00. Their special services are recognized by the federation very reluctantly, if at all. No one doctor is supposed to cut too great a slice of the fixed total at the expense of the others.

The system has led to the unprecedented proletarianization of the German profession, disregarding a small minority. Specialists receive such very moderate fees as 50 marks (nominally \$12.00) for an appendectomy. But they fare better than the average practitioner who has to handle up to 100 consultations and visits a day—to make a living. Even under the stable monetary conditions of the late 1920's, a doctor was paid, for a consultation, less than one-half of what a barber received for a haircut. By this time, he is even worse off; remuneration rates are almost unchanged, while the mark's purchasing power has substantially depreciated again.

DOCTORS' STATUS UNDER BEVAN

Bevan's intention to reduce the profession's status is quite apparent. In accordance with the collectivist undertone of his scheme, most *specialists* are to become employees of the governmentalized hospitals at moderate salaries. Appointments, promotions and special remunerations already are colored by Party politics. The specialists can choose to be part-time employees and are then paid in proportion to the number of hours they devote to hospital work. Their regular basic pay for full-time staff work begins with an annual 1,400 pounds sterling or \$3,900 paid to those up to 31 years of age, and rises to about \$7,000 at retirement, with remuneration for "special merits" to a fractional number.³

The specialists who used to serve in hospitals for no pay—which is characteristic of their attitude under the free enter-

prise system—now receive a uniform per-hour fee without much regard to qualification, efficiency, knowledge or experience. They are pressed into the bureaucratic routine if they sign up for full-time with security of tenure and a seniority incentive. In any case, the nationalization of their function largely eliminates the private practice of specialists, which is their major source of income. The beginner may be better off than before, and the untalented or shy may prefer the mediocrity of safe tenure to the hazards of the market place. But the body of medical experts becomes an adjunct of the Ministry of Health, dependent for promotion presumably on good political behavior rather than on accomplishment and the patients' satisfaction.

"Men who for many years," stated *Time and Tide* (London) "have been acknowledged by their colleagues as consultants and specialists now find themselves reduced to the rank of Senior Hospital Medical Officer with an income which is quite inadequate and with little hope of supplementing it from private practice. Does the man on the stretcher know what the specialist will get for healing his wounds, treating his disability, saving his life or relieving his suffering? He will get fifteen shillings (\$2.10). Take away income tax and he is left with seven and six-pence (\$1.05)."

If the specialist's chances are reduced to a modest, though relatively secure, economic existence—at the potential price of subordination to bureaucratic routine and political favoritism—the *general practitioner* carries the full burden of the lowering of professional standards. He is on a yearly capitation fee of nominally eighteen shillings (\$2.52) per patient paid out of a pool of \$112,000,000. But before distribution of the pool, mileage fees (about \$5,600,000), fees for emergency treatments, a premium to provide for superannuation, etc., are being deducted.

Even with 3,000 registered patients—almost 2,000 too many, from the point of view of medical responsibility, and a number considered to be greater than can be attended by the doctor of average physical or mental endurance—the doctor's gross annual income would be less than \$7,600. But given the amount of paper form-filling involved, any such exceptionally "fortunate" practitioner is in need not only of ample office space—

in the right location—and of equipment, but also of full-time secretarial and assistantial aid, the latter, at any rate, during his vacation. All told, for a year or two, his net income before taxes perhaps might reach \$5,000, but he could not keep up the tempo of work needed without serious damage to his professional self-respect and to his health. The vast majority has little chance of drawing that much. And few are lucky enough to retain a share in the dwindling volume of private practice. It dwindles for a second reason: the fewer private patients, the higher the doctor's fee to each. Excessive demand on the doctors' time reduces its availability and raises its price.

In any case, the British practitioner's income depends on the number of patients who register with him. It bears no relation to the number of consultations and visits, to the amount of time and discomfort devoted to the individual case, to the ingenuity of his art or of his science, to the success or failure of diagnosis and therapy—nor to the patient's ability to pay. The pecuniary motive that provided a positive incentive for higher quality of performance is turned in the negative direction of driving for more patients and less "work" with each of them.

The *dentist* is paid on a schedule that assumes his average prewar earnings as the equivalent of \$4,500, at the latest pound-dollar rate, and actual chairside work as 35 hours per week, adding a 20 per cent allowance for the rise in the cost of living. (Wages have risen 124 per cent.) Each individual performance has been timed and the remuneration fixed according to the number of minutes it takes, practically ignoring such non-measurable, "capitalistic" standards as the effort, inventiveness, art, or risk-taking involved.⁴

As long as the orgy of tooth-pulling lasts, the dentists work overtime on overtime, putting patients in chairs side by side, but at least "earn well." True, their professional expenses are officially estimated at 52 per cent of their income. Even so, they are making hay while the sun—Bevan's miscalculation of the demand—is shining. Gross earnings as high as \$40,000 per annum occurred in some instances. But after ten months of such bonanza, the Minister first decreed the confiscation of all dentist incomes over and above a gross of \$17,000. Later, this was changed to a 20 per cent cut across the table.

DOCTORS' INSECURITY The experience of panel systems provides the lesson that unless the doctors are regimented, the schemes' costs of operation never can be controlled. And to be regimented they have to be pauperized. Mr. Bevan deserves the distinction of having clearly recognized the inherent logic of the system and of having drawn the conclusion manfully. That his intention is to lower the economic status of the profession so as to be fully able to control it is shown by some of his methods. They would be unintelligible if looked at merely from the point of view of saving operating expenses.

British practitioners used to provide for their own retirement by selling their practices. The new scheme prohibits this once and for all. Physicians already practicing are compensated, if they enter the new scheme, by an annuity that represents, supposedly, the average capital value of their practice. Henceforth, subterfuges, such as a doctor giving up his office space for the benefit of another, are to be punished severely. Evidently this has nothing to do with the quality or quantity of medical service. Why, then, the interference with elementary property rights, equivalent to prohibiting the sale of patent rights or of business "goodwill," all of which would be unconstitutional in the United States? The reason should be obvious: to compel the medical man to seek a safe haven in government service for which a modest retirement pension will be provided.

YOUNG DOCTORS' PROSPECTS A further consequence is even more serious. How should a young practitioner start his career? To hang out a sign and to wait for patients is extremely hazardous for any one without ample means. Until the new scheme came in force, the young doctor either had enough means to buy an old colleague's practice or he could borrow from a bank, pledging his future income. Similarly, he could buy a partnership in a medical firm—which is now prohibited, too, except in the dying-out private practice—and be introduced to the patients by the senior partner. In either case, in due course, he would have liquidated his debt and become independent.

Now, he has to wait until a local executive council announces a vacancy and has then to apply. That he has to

wait many more months for a decision is a minor detail. What matters is that the local doctors tend to exclude new competition. Due to the narrowness of their own incomes and to their need for more patients, they tend to become a closed group, trying to keep out new competition. In all likelihood, the young doctor's chances amount to an opening in some remote area, with few patients, no private practice on the side and difficult living conditions. He may even run into the problem of finding space for his office and for his family, given the housing shortage and the embargo on acquiring office space through the purchase of a practice.

Outside of Russia, nowhere has the intentional strangulation of the general practitioner gone so far as in socialist Great Britain. But even in Russia, as elsewhere on the Continent, the poorly paid practitioner may suggest that his panel patient become a private patient. That, too, is prohibited in Britain.

As to the young specialist in Britain,⁵ his chances are equally reduced unless he enjoys a bureaucratic existence and the political game. To start a new private practice is virtually out of the question. The same holds in many other compulsory systems. Wherever the doctor is being paid by the authorities and not by the patients, the outcome of compulsion is a set of fees that does not cover the investment in expensive instruments. This has an additional effect that could scarcely have been unintended: it forces the patient into governmentally controlled dispensaries which can afford the investment—at the taxpayer's expense.

C H A P T E R N I N E

A Frustrated Profession

I^N every compulsory set-up, the overwhelming majority of the medical profession lives in a never-ending feud with the administrators and their political backers. The feud may be simmering at one time or erupting at another, but this domestic Cold War is being carried on by both sides with a bitter, time-consuming intensity that diverts a great deal of energy into a totally unproductive channel.

A REVEALING CONVERSATION

The following conversation, in June 1949, with a distinguished member of the Netherlands' "social" bureaucracy is worth recording:

— "How much do your general practitioners earn?"

A. "They are paid a capitation of 4.68 florins for each potential patient registered with them."

— "You mean to say that the doctor receives a per capita fee of about \$1.60 a year in American money?" (This was before the September, 1949, devaluation. It is \$1.10 at present.)

A. "That's it exactly."

— "How can he live on that?"

A. "You speak like a doctor. He can have as many patients as he can handle."

— "How many general practitioners are there in the country and how many members in your panel system?"

A. "Out of the total population of $9\frac{1}{2}$ millions, the panels cover 6 million people and there are about 6,000 practitioners."

— "That gives an average of 1,000 patients per panel doctor, or an annual income of some \$1,600 for each (\$1,100 by now). Presumably some have more and some less patients which still leaves the question open on how they exist in view of the fact that the cost of living in Holland, controlled as prices are, is not very much lower than in the United States."

A. "Well, the doctors should get what they need from their private patients. There still are some $3\frac{1}{2}$ million people left who are not panel members."

— "What about the doctor in a working men's district where everybody is registered? He cannot have many private patients to speak of?"

A. "Then the number of his panel patients is the greater. Some of them have 4,000 or more."

— "If so, how much time can a practitioner devote to each of them?"

A. "We figure on an average of three minutes per consultation. What is wrong with that? An experienced physician does not need more time on the average."

— "That includes the time devoted to paper work such as filling out forms for sending the patient to a specialist or to a hospital, writing out prescriptions, etc.?"

A. "It does."

THE MEDICAL FRONTIER Private practice constitutes the professional Frontier under governmentalized medicine. (Holland now is planning to extend the scheme to the farm.) As the Frontier shrinks, so do the profession's chances to supplement its earnings from outside panel practice. What is more, its bargaining power *vis-a-vis* the governmentalized set-up shrinks. More and more physicians become economically weak in the literal sense and have to accept the terms offered or imposed by an all-powerful monopolist. They face a single organization that "bargains" with them on behalf of the vast majority, if not the totality, of all patients. The result is accordingly disadvantageous to them.

As a matter of fact, a major objective behind the drive to expand medical compulsion is often to strengthen its stranglehold on the profession, ultimately to force it into governmental service at more or less uniform, always at relatively low, salaries. That is one reason why a man of such anti-capitalistic make-up as Aneurin Bevan is anxious to extend his benevolence into the richest home: to eliminate the private patient, the doctor's economic "backbone." Observers could not fail to note a similarity between this process and the Soviet technique in forcing the peasantry of the Satellite countries into the communized *kolchos*: first by monopolizing the market for farm products and then by squeezing their prices until the peasants surrender.

The further the schemes expand, the greater the financial strain and the more imperative the necessity becomes to economize. Needless to say that in every democracy the economy axe tends to fall—another law of political "dynamics"—on the group with the least political, vote-getting power.

SUPPLY OF DOCTORS The ever-lasting conflict between the obligatory schemes and the practicing doctors creates a new sort of class struggle. The Nestor of the German social insurance administration is responsible for the recent statement that the Number One social problem of his country is the problem of the doctors' survival. This is no exaggeration so far as Germany is concerned. From about 27,000 in that whole country in 1900, the number of doctors other than dentists in the Western Zones alone has risen to over 60,000, probably the highest ratio to population (1 to 700) in the world, this for one of the world's most impoverished nations. Also, 20,000 medical students are being "processed" presently in Germany, compared with 22,000 in the United States. The German doctors' economic status has slumped accordingly.

The German panel bureaucracy is an exceptional one. It does not build polyclinics or ambulatoriums and it sympathizes with the doctors, verbally at least. Elsewhere, the officials (and the politicians, including the trade union bosses) are more or less openly hostile to them. The physicians are being denounced as ruthless egotists who prefer their profits to their humanitarian duties. Swiss sick panel managers assured this writer that 15 per cent of the physicians are plain negligent on

duty, and 10 per cent outright fraudulent—meaning that they use more medical devices chargeable to the panels than is absolutely necessary for the benefit of the patients. In France and Belgium, the doctors are considered by the administrators and their following as the number one sickness of the respective health schemes. Even in public it has been hinted candidly, and not quite without foundation, (e.g., by the “father” of the French social insurance, the former senator Antonelli) that the profession’s resistance against “regimentation” is due to the fear of losing its chances of income tax evasion once its incomes are controlled.¹

The undisguised animosity with which a statesman like Bevan treats the profession and the extensive propaganda of undiluted abuse his Party has carried on against them are matters of well-known records. In this respect, too, Bevan’s attitude² is similar to that of his congenial predecessor, Lloyd George.

PAUPERIZATION AND BARGAINING POWER The Dutch doctors’ case seems to be the limit to which the systematic pauperization of doctors has gone so far. Already, they are fighting back, demanding—a ten cent higher capitation (per year!). But their chances are meager. They ask for raising the members’ contributions, or cutting the panel administrators’ salaries, or exacting a subsidy from an unwilling Parliament. It takes a very strong pressure group to get any such results; and the doctors in Holland are not even a closely knit group.

The law of supply and demand has a measure of application on the market for doctors as well. The fantastic increase in the demand for medical services in this generation’s lifetime should have worked out to the profession’s economic benefit. But the compulsory systems not only attract flocks of men and women into medical work, sharpening the intra-professional competition, but actually foster a mass-production of doctors, as in Germany. (In Russia, they multiplied from 19,800 in 1913 to 85,900 in 1934.) Moreover, the physicians are faced with a monopolistic super-power which they can scarcely match by their own organization. Their bargaining power is greatly reduced by the fact that they are “natural” individualists, not fitted for unionization. As professionals devoted to their life

work, they often are "naive" in matters of politics and as a rule lack political leadership. Both their professional ethics and the pressure of public opinion work to their disadvantage when they are challenged by political forces. The German *Hartmann bund* repeatedly has threatened to strike, but never dared. In public opinion, the doctor still is, or should be, something of a Samaritan who works for the benefit of humanity. (Just what would have been the Good Samaritan's attitude to an onslaught of distressed hypochondriacs?)

Once the politicians arouse public opinion in favor of a scheme, or of its expansion, the objection of the profession—even if unanimous—falls on deaf ears. Typical is this example from New Zealand: the "violent" resistance of the doctors against the introduction of a new scheme accomplished no more than to raise their fees slightly.³ "By some perversity of nature, many men and women who willingly accept the clinical opinion of their doctors refuse to listen to their critical opinion," commented an English magazine on the lack of support for the doctors' resistance against Bevan. Possibly, the public senses that the doctors have a vested interest in the matter. If so, their sensitiveness toward the vested interest of the politicians is much less acute.

DOCTORS' SURRENDER

The source of greatest weakness in the doctors' position is the fact of their readiness to compromise. A minority of them actually advocates compulsion, and even the majority is willing to cooperate, if only on its own terms. That makes them suspected, of course. Instead of taking the position of principle, they argue about technicalities and honoraria, overlooking the public reaction. They overlook two more things, as a rule. Once the principle of compulsion is accepted, the amount and terms are not being determined by the doctors or upon their advice. And even if the terms conform at the outset with the professional proposals, the schemes expand sooner or later far beyond the original intent.

In the recent case of Britain, one reason why the doctors' resistance broke was the fact of defection in the medical ranks themselves. When it came to the showdown on the Bevan scheme, 35 per cent of the profession, including the top leadership of the British Medical and Dental Associations, capitulated.

lated. (A chief executive of the latter has been promptly promoted to a high rank in the Ministry of Health.) But the majority was railroaded into submission by the threat that those who did not sign on the dotted line would lose all claim to compensation for the capital value of their practices. Nearly 19,000 out of 21,000 doctors and 9,000 out of 10,000 dentists have signed up. (The latter were lured into the scheme by the prospect of unprecedented incomes—which are fading out gradually.)

The moral of this story is that in the final analysis the doctors can blame themselves if they lose out—if their incomes are reduced at once by 25 per cent on the average, as under Bevan, and their professional standards lowered in an unmeasurable fashion—just as a nation can blame itself if it foregoes its liberties, be it by submitting to intimidation or by letting itself be bribed into “collaboration.”

*"One should strike too hard at times in order to strike just right."
(Il faut frapper trop fort parfois, pour frapper juste.) Talleyrand.*

C H A P T E R T E N

The French Doctors' Escape

W

HETHER a sentimental humanitarian or a money-minded entrepreneur, a conscientious scientist or an artist for the sake of art—the doctor almost invariably loses in the compulsory systems. Those of the leading Latin countries of Europe, France and Belgium are exceptional.

THE BELGIAN SET-UP

The Belgian physicians in their majority organizations are "not on speaking terms" with the top management of the new (1945) obligatory set-up, in the construction of which they were not even consulted. They carry on as before, but in an uneasy state of uncertain outlook, while the major panels are building up gradually their own polyclinical and pharmaceutical facilities. The outcome will depend on political and financial constellations, with the (recently defeated) Belgian socialists striving for full-fledged statism in the medical field. Presently, 25 per cent to 33 per cent of the official medical honoraria comes out of the panel patient's pocketbook, and more if the doctor charges above the legal rate. So far, the Belgian profession is holding the precarious line of independence and economic status, following the policy line of their French colleagues.

THE PECULIAR FRENCH SYSTEM

A near-unique situation obtains in France, with very far-reaching consequences. They affect the status of the doctors as well as the quality of the medical care.

As in no other country, the medical association of France established and so far has succeeded in maintaining four principles:

the patient's free choice of doctor (and the doctor's implicit right to reject the patient);

the "sanctity" of professional secrecy, extending even to surgical acts;¹

the absolute independence of the doctor in relation to the authorities, including his freedom to prescribe as he thinks right; and

the "directness" of doctor-patient relation, with no bureau to serve as go-between (no *tiers-payant*).

The last point is of greater significance to all concerned than meets the eye. It permits the French doctor to charge according to his position, to the service rendered, and to the patient's ability to pay.

This essential ingredient of the French scheme was already introduced in 1930 so as to avoid the pitfalls of the German system which the French maintained in Alsace after 1918. It has been preserved in the new scheme. It provides for the payment directly to the doctor. The patient in turn collects from his panel, minus 20% of the official fee. Medical fees are regulated in one of two ways: either by contract between each *caisse primaire* and the *ordre des médecins* of the respective department (county); or by a geographically scaled tariff issued by the Minister. In about 50 per cent of the departments, typically in the poorer ones, agreements have been reached at rates slightly above the legal minimum. But in the wealthier regions, in Paris especially, the doctors refuse to accept the modest concessions offered by the panels, and prefer to work without contract, i.e., under the legal tariff—which they simply ignore, charging what the traffic can bear.

In Paris, a simple consultation for a panel patient should cost at present about 240 frs., approximately 70¢, against the usual 20 frs. before World War II, while the cost of living has mounted at least 19-fold and the number of private patients has declined greatly. The *caisse* would be willing to raise the fees somewhat. But the physicians charge from nothing more (occasionally even less, which is illegal) than the

official tariff to some 200 per cent above it. Some fee between 300 and 600 frs. seems to be the current charge of general practitioners. And the patients pay willingly. The trouble starts when they return to their panels and find that they can collect only 80 per cent—of the tariff rate. In effect, therefore, they pay one-half or more of the doctor's bill unless it is a matter of "long" illness, meaning more than three months, or serious surgical and dental intervention. In that case they may have to do a lot of time-wasting and hard-bargaining with the panel before they recover the full amount of the official rate.

CONTROL BY "DEDUCTIBLES" Thus the French medical profession as a whole preserves its own economic level—a French level. Actually, it may be doing better, the panels claim, than ever before. And it preserves some things far more important. Monsieur Laroque himself, the director of his nation's all-round social security set-up, made the point repeatedly that his countrymen could not be trusted to observe obedience to the law as a Britisher might. Frenchmen would take too much advantage of governmentalized medicine if they were not held back by being forced to pay a 20 per cent "deductible" out of their own pockets. It follows *a fortiori* that they are still more restrained if responsible for paying 50 per cent of the doctor's fee. Indeed, if the French compulsory system manages to operate on a 10 per cent visible deficit "only," if its doctors are not over-worked and its hospitals not constantly overcrowded, it is so because the scheme is not under the kind of run to which other systems are exposed.

The average panel member has to think before rushing to the physician or calling him to the house and to think twice before taking the time of an outstanding specialist who charges proportionately more. A sort of treatment is available free of charge—if the member does not mind submitting to the paramilitary, antiquated and often unpleasant polyclinic facilities for out-patients in such hospitals as those owned by the semi-governmental mammoth organization called the *assistance publique* of Paris.

That is not all. The less one goes to the doctor, the fewer cash benefit claims and pharmacy bills should arise. Industrial

absenteeism is tempered, too, and the "morale" of the public strengthened, or at least its worsening is slowed up.

Above all, the human relation between doctors and scheme patients does not deteriorate. And the scientific standards of French compulsory medical practice are maintained on high levels—apparently on much higher ones than in countries with a comparable experience in governmentalization. Nor did the French system produce the acrimonious public quarrels, strike threats, bitter recriminations, etc., between panels and physicians, as did its counterparts elsewhere. What suffers is, of course, the popularity of the system. The political advantage is largely dissipated. The Frenchman who has been told that in exchange for a moderate charge on his payroll, plus a 20 per cent "deductible" (from low honoraria), he has the doctor at his disposal, together with all the other good things dispensed by the doctor, finds the price to be paid most unsatisfactory. Needless to say, interested politicians and administrators share the disappointment.

SECRET OF STRENGTH For the time being, there is nothing the latter can do about it beyond grumbling and expressing grave doubts about the legality of the professional behavior. Time and again, they try to call individual doctors to "explain" before the *ordre des médecins*, but in matters of fees French professional solidarity is unshakeable. What is the "secret" of their strength? Perhaps it is due to the fact that in France, the classical country of the revolutions, the middle classes still preserve some of that old-fashioned spirit of self-reliance.

In any case, the doctors' influence over the health scheme, disregarding the some 700 *confrères* already on its payroll, is nil. As a group, they are treated by the scheme politicians with contempt and threatened with dire consequences. Nor is it a matter of too little supply of physicians. The some 30,000 practicing members of the French profession—for 42 million people—do not represent an appreciably lesser supply per capita of population than exists in England or existed 20 years ago in Germany. There are some 6,000 doctors in Paris alone. Of the 600 young physicians graduating in Paris last year, 300 were reported in no position to buy their own medical "cabinet." It is the type of legislative set-up that creates from the

outset the more advantageous climate—the fact that the scheme does not distribute directly benefits in kind. It merely compensates for the patient's expenses and not for the full amount. Also, it is the cooperation of the public with the doctors, its willingness to recognize the rationale of satisfactory medical incomes, that permits the latter to “get away with murder” as the other side sees it. The official scorn is the more poignant, since the French public puts the blame for its own dissatisfaction squarely on the scheme itself.

REPER- The consequences are manifold. For one thing,
CUSSIONS raising member contributions, i.e., the rate of payroll deductions, is out of the question so far as the beneficiaries are concerned. Not getting what they were promised—all services for no more charge than a nominal deductible—they turn the ire of their deputies and of the popular press on any attempt to squeeze more out of their own pay checks. Politically, nothing hurts the entire scheme more than the so-called unreasonableness of the doctors who, incidentally, seem to be very well organized and also well-versed in the devious ways of French politics. An organized minority among them actually “ignores” the compulsory scheme altogether. Still, this writer has no answer to the obvious question—why, of all peoples, are the French and Belgian doctors alone able to resist the political pressure? And how long will they be able to do so?

Whatever the repercussions, the result of the French doctors' highly controversial policy is that the burden of “minor maladies” is greatly reduced. The cost of the *petit risque* amounted (in 1948) to about 15 per cent of the total sickness scheme outlay, apparently the lowest ratio in all of Europe. It may not pay the workingman to run to the doctor, or to call him in, on every imaginary or minor occasion. The first two sick-tickets he signs are valid for only eight days each, with no cash benefit for the first three days. The medical fee is better bearable for people in higher income brackets, who can afford half of the actual honorarium—a sad commentary, incidentally, on an institution that is supposed to provide for the poor.

The low income recipients, who must refrain from using the system unless they can expect at least an eight-day vacation out of it, naturally try to stretch each and every case to eight

days at least and to make the most of other benefits which the doctor can bestow. Over-staying in the hospital is a favorite sport, resented and combatted by the panel administrations, but is promoted, in Paris, by the autonomous hospital system. That system needs the occupants to cover its unmanageable costs per bed—50 per cent to 100 per cent higher than in private institutions. Pharmacies are another "compensation" the patients enjoy. With remarkable regularity, the average consultation is followed by a prescription bill (in spite of a 20 per cent deductible on that, too) about 50 per cent higher than the official honorarium of the doctor.

To impress on visitors how wonderful his brainchild is, Monsieur Laroque, the chief of the scheme, likes to point out that, as head of a large family, he himself takes full advantage of it. He does not seem to realize the irony of the fact that he and his kind are the one group that really profits by it, contributing barely one-half, in proportion to his income, of what the average worker does, and being able to afford one-half of the doctor's fee, which may be far too much for a worker's pocket book.

THE PRECARIOUS BALANCE OF POWER

The political balance is being held by the French doctors against the compulsory scheme. By virtue of the legal construction of that scheme, and especially by violating the spirit if not the letter of the law, they manage to maintain something approximating the free enterprise system in medicine. But it is a most precarious equilibrium that cannot last, and the omens are unfavorable. The scheme managers, and the politicians behind them, plan to construct, in due course, polyclinic and dispensary facilities. They pull the strings to get hold of the hospitals. All of which would make the position of the independent doctors very difficult. Moreover, public dissatisfaction with the scheme is mounting, and the schemers play on that. Since middle 1948, the Socialists, while still in the cabinet, have lost much of their influence, but they might regain it. With the number of doctors increasing faster than the population, and with an increase in propaganda for continuing the horizontal expansion of the scheme so as to eliminate private medical practice, the conflict of the profession with the obligatory system of France might lead to a dramatic dénouement.

Diseases of the soul are more dangerous and more numerous than those of the body. (Morbi perniciosiores pluresque sunt animi quam corporis.) Cicero, Tusculanarum Disputationum.

C H A P T E R

E L E V E N

The Ethics of Compulsory Medicine

SO FAR, the scientific and ethical standards of medical practice have not suffered as appreciably in France and Belgium as they have under compulsory systems in other countries. But the threat of deterioration and corruption is hanging over all of them.

PROBING THE ABUSES The officials of every health scheme grow indignant if the soundness of its operations is questioned. *Some* corruption is generally admitted. Is there a human institution that is free of mischief?¹ On the other hand, every country which I have visited is buzzing with stories about the waste of sickness funds and functions. Are they scattered cases? Is it irresponsible gossip? No statistical evidence is available to gauge the amount or degree of "criminality"—except from Russia. Soviet papers reiterated in the middle 1930's that as many as 36 per cent of all sickness-certificates were fraudulent.² How they knew it so precisely is a mystery. West of the Iron Curtain, the subject rarely is broached officially. But no Western officialdom lacks open-minded and outspoken members. Close questioning on specific topics brings to light revealing answers. The same official who is indignant about general charges may readily admit dubious practices in some specific field with which he happens to be familiar.

Practicing doctors should be the natural witnesses. Overwhelmingly, their testimony is damaging. But it is being deprecated as biased and partisan.³ Of course, it is not free of pecuniary considerations. Nor is the judgment of industrialists

who foot the bill both by their contributions or taxes and by employee absenteeism. However, the evidence of a convicting nature is too abundant to be ignored. Published material that never has been contradicted officially and seems uncontradictable breaks into the open time and again.

Evidence of serious shortcomings of the schemes has been produced by their own honest and intelligent supporters who clamor for a reform of one sort or another. The shortcomings are further substantiated by the controls instituted to combat them and by the mutual accusations of the conflicting groups. The clash between panels (or ministries) on the one side, and doctors on the other is not the only "class struggle" in compulsory medicine. The scheme administrations are often at odds with their own national authorities, pharmacists' organizations, and hospital managements. The accusations reach at times extraordinary intensity. Sooner or later, each group turns to publicity for support.

Moreover, administrations, doctors, nurses, pharmacists, almost every one connected with the functioning of the schemes has a great deal to blame on the greediness of the beneficiaries. They in turn blame every one else. And often even more revealing than the verbal free-for-all are the "between the lines" implications of administrative measures. The central *caisse* of Paris, while denying the system's responsibility for absenteeism, placed two "motorized" staff doctors on the job of checking its own employees; the result was an immediate decline of absenteeism from 12 per cent to 5 per cent among its 6,000 women employees.

CIRCUMVENTING THE LAW Compulsory medicine is open to a large measure of illegality due not only to the extreme complexity and clumsiness of its mechanism, but also to the very nature of its operations. In Germany, as in France and Belgium, and even in England, rumors persist about people exchanging prescriptions for perfume or toothpaste. Such "minor" infractions of the law—by both the patient and the pharmacist, in this example—are relevant merely as indications. Some schemes offer more opportunity for illegal or extra-legal manipulation than others. Much depends on the national "temperament," too. Everywhere, there is an appreciable residue of undiluted law-break-

ing, stemming from the fact that public funds are involved which the individual is inclined to regard as an economic "no-man's land."

If it is true that opportunity makes thieves, there must be quite a few around in compulsory medical systems. Especially so, when those contributing to some extent feel that they do not get equivalent return on their "investment." Take the French technique of sick tickets which the patient has to secure at the panel, to be returned with the notations and signature of the doctor. What if a beneficiary fills them out himself, falsifying a physician's signature? One such case was detected in Paris, when a fellow repeatedly prescribed for himself—at the time of the food shortage—such quantities of cod liver oil that the panel became suspicious. With a little more discretion he might have gotten away with it. What apparatus would be needed to verify the signatures of every one of the some 6,000 practitioners in the Paris area, with tens of thousands of sick tickets coming in every work day?

The new British scheme has found a solution to all such control problems—no checking at all. How much, then, is true of the reports published in the newspapers, by apparently trustworthy people, that eye glasses, wigs, hearing aids, and even dentures are used in the "pubs" as means of payment, new ones to be ordered next morning, is anyone's guess. (An estimated 30 per cent of all eye glasses distributed under the Bevan scheme free of charge are duplicates—not counting the renewal orders.) There is nothing to stop a Britisher, as the Select Committee on Estimates of 1949 found out, from having any number of dentures made, if he cares to change dentists.⁴

Ingenuous tricks for contravening the law, without violating it, develop under the Bevan scheme. A couple registers with two doctors; the man's official practitioner is the private doctor of the wife, and vice versa. Each is treated by his or her private doctor whose prescriptions are sent to the official practitioner of the spouse with a stamped returned envelope. The prescription returns on the official form and the medicine is collected "on Bevan," thus evading the law that prevents the doctor from treating privately his officially registered patient. Such examples of semi-illegal, not punishable evasions could fill a volume. And numerous cases of actual fraud are

known to have occurred in the compulsory industrial accident insurance plans as well as in the sickness schemes.⁵

THE SUBJECTIVE RISK

Crude extra-legality and open illegality are a minor though disquieting angle of a fundamental issue. The real problem is one of basic ethics as well as of public finance and of individual health care. It should not be surprising to find that these are three aspects of one and the same problem: of human nature pressed into an institutional set-up that ignores, or pretends to reform, elementary tenets of human psychology.

The dire fact is, to put it bluntly, that governmentalized medicine tends to bring about a conflict between the natural, perhaps even subconscious interests or instincts of the persons directly affected and the schemes themselves. These conflicts undermine the functioning and negate the objectives of compulsory medicine.

The crux is what the insurance experts call the subjective risk. Sickness depends on objective causes beyond the control of the afflicted person. But it also depends on little known processes of a mental and emotional nature. To be sick is, to an undefinable but very substantial extent, a matter of "psychology." To become a "patient"—admitting or claiming helplessness—is another process regulated by purely mental as much as by "factual" happenings.

The adage "people who get everything for next to nothing think next to nothing of everything they get" epitomizes a human reaction so automatic that it is scarcely even conscious. Given the meagerness of our pocketbooks, we cannot help but be rational to the extent of economizing with things which are expensive. But that which is cheap is "cheap as dirt" and need not be treated with care or consideration.

The new apostle of Social Security, Sir William Beveridge himself, has warned that "the danger of providing benefits, which are both adequate and indefinite in duration is that men, as creatures that adapt themselves to circumstances, may settle down to them." They settle down, indeed, and "smarten up" to them. They do so the more, the longer the scheme is in operation. What is done at first surreptitiously by uninhibited persons only, tends to become common practice.

The real problem is rooted in the semi-conscious twilight in which the behavior of the individual is determined by the interplay of conventional ethics and traditional habits, of rational will-power, economic interests, emotional strains, objective and subjective symptoms of illness, and manifold circumstances. If the factory workers of the Rhone Valley year after year are "sick" for a week or two just at the time the peach crops of their little gardens ripen, is it or is it not to draw the sick benefits (half pay) and to reap other advantages as well? Or did they merely postpone for a convenient occasion a treatment they needed sooner or later? Similar questions could be raised with respect to the "seasonal" ailments notoriously displayed by seasonal workers, to the chagrin of all sickness schemes. Their query is how to stop what they regard as unfair exploitation of their resources without hurting the justified claims of the bona-fide patients.

The notorious coincidence of women's laundry days and house-cleaning seasons with their sick leaves constitutes another headache of the same type to the panels whose budgets have to absorb the bills. Characteristically, the number of sickness cases reaches record figures not only in depressions, among the unemployed (where there is no unemployment insurance), but also in inflations of the type in which black markets flourish. It then pays to get half-pay from the scheme and to go "blackmarketing." Another widely favored sport is to round out one's one or two weeks' paid vacation by one or two weeks' (half paid) sick-leave.

THE ETHICS OF SICKNESS These are comparatively simple situations, although loaded with consequences. But where is the border between legitimate and illegitimate claims in the instance of hypochondriacs—experienced panel practitioners estimate them at 10 per cent to 15 per cent of all patients—to whom being ill is a quaint form of recreation? They monopolize the doctors and even the hospitals to the detriment of the seriously ill. What of the army of psychosomatic sufferers, and all the borderline troubles and irregular symptoms? The margin between right or wrong is very thin when the individual lacks standards by which to distinguish, and the community cannot provide effective sanctions of enforcement. All that may happen to him who claims

too much is that he may not get it. In any case, he pays no extra price and has no punishment to fear. If he refrains from using the facilities offered (at little or no cost to him), he still has to pay his contribution and some one else may draw the benefits. And no one concerned need be bothered by his conscience—no rules of conventional morality may have been offended. Molière's immortal *malade imaginaire* could afford the role only by virtue of his money. The modern hypochondriac is not inhibited by such details if he is "insured" in a scheme.

Indeed, what is unethical in violating a police rule—a favorite pastime of Frenchmen—if it is to one's advantage and apparently no one else is hurt? Since the idea of the institution is to serve my health and since health is a wholly subjective concept, why should I not make the most of the institution? To assume or stipulate that people should subordinate their own concrete interests, as they understand them, to the abstract ideal of a common welfare, which is a vague term to most of them, is as futile as it is typical of Utopian thinking. It presupposes that the common man is something of a hero or saint in his everyday life. And it ignores the role of the emotional dynamics even in organic ailments.

THE PROBLEM OF LITTLE MALADIES

The question of consumer-ethics is relevant to what is called *minor maladies* (bagatelle cases). Well-meaning advocates of obligatory medicine like to believe, and to make others believe, that all that is needed is to control the would-be patient who is pestering the doctor with a head cold—or with "cold feet," for that matter—and similar troubles and draws sickness benefits for periods up to 14 or 21 days. "Minor maladies are those diseases which the patient thinks it not worthwhile to take to the doctor" (G. S. Williamson). When the doctor is freely accessible, like water or air, anything might be taken to him. The adverse effect on people's morale as well as on their productivity should be obvious. The problem is particularly serious in the case of irregular workers—and of office employees, who, in most of Europe, are entitled to a month sick leave (at the boss's expense).

Officially, the short maladies are defined as those lasting two weeks, in one country, ten days or three weeks, in another. The

time limit is purely arbitrary, introducing an additional element of social injustice and bureaucratic red-tape. In any case, the short maladies are the hypochondriac's paradise and the large family's playground. But "all of them have the makings of major maladies," the compulsion advocates retort. Anyhow, the elimination of the "little risk" in the compulsory system is a *political* impossibility. Nothing advertises a health scheme more effectively than the fact that a doctor is at every one's elbow literally "at a sneeze."

The claim of the French panels that the cost of short maladies amounts altogether to less than 15 per cent of all costs is slightly incorrect. The expense for doctors and pharmacies incurred by patients who do not stop working seemingly is not included in that figure. But inhibited as the French patient is by the extra-fee of the doctor, as pointed out before (Chapter X), abuses creep in. One indirect proof by official statistics of such abuses in the *petites maladies* is the fact that the mothers' demand for minor medical care moves in exact proportion to that of their children. Why should French mothers have just as many stomach aches and similar short ailments as the children? The parallel run of the two figures in practically every single one of the 100-odd panels could scarcely be accidental.

Outside France, the minor maladies seem to absorb as much as 20 per cent and 30 per cent of the scheme expenditures. But chances of over-medication are omnipresent in "long" sicknesses as well. They, too, raise virtually unsurmountable problems—and costs—of control. They are most burdensome on the doctor's visiting time, on the specialists, pharmacies and, last but not least, on the hospitals. But the real crux is the inevitable effect of the compulsory system on that patient-doctor relationship.

THE LOGIC OF ABUSES What the scheme administrations are most anxious to prohibit and what they are faced with constantly is the doctor's alleged or real collusion with the patients in providing sick pay for those among the latter who supposedly are able to work.

Boswell credits Dr. Samuel Johnson with having said: "No man would be a sailor who has contrivance enough to get himself into jail." It might be said in earnest that no sensible

man is going to work at full pay all the time if he can have in-between a vacation at half-pay, or a hospital rest at no cost. Who has no minor physical or nervous trouble of some sort at some time? As a French doctor asked me rhetorically: "Don't we all need eight days' vacation?" Of course we do, but the question is: who will foot the bill, and what will happen to the national output if, on top of shorter weeks, shorter hours and legal, paid vacations, we all take out time and again an additional eight days? These questions are of particular urgency for Europeans whose per man-hour productivity has declined, and whose economic deficit is being paid by the United States.

That half-pay with no work has a temporary preference, in the individual's schedule of desirable things, over uninterrupted work at full pay is not only an *a priori* certainty to anyone who has an inkling of human attitudes toward factory and office work. It can be demonstrated statistically as well. In every scheme, the number of sick days per insured tends to rise. France, e.g., is the country where one would least expect it to happen, due to the impediments—such as partly self-paid doctor's fees, and other controls—that the French system puts in the way of the would-be "cheater." But the French figures indicate a different story. By 1948, per capita sickness days had doubled those in 1938, as pointed out in Chapter VI.

The average beneficiary is "ill" either twice as often or twice as long as before the last war, this at a time when food shortages and black markets have virtually vanished. While the black markets flourished, sick-days (at half-pay) stymied French industry. For the third quarter of 1947, as an example, 245 textile plants of the Lille-Roubaix-Tourcoing region reported that of those absent from work, 58 per cent stayed away less than 8 days, and 19.5 per cent, 8 to 15 days. The overwhelming role of the short malady was evident in that case. The damage it causes to industrial productivity may be far more serious than its costs to the sickness scheme itself.

DOCTORS' ETHICS? The more facilities the compulsory schemes offer to the sick, the more people are sick, say the

French doctors. Swiss panels tell the same story from their own angle. A new specialist establishing himself, they say, builds up his clientele within a year or two without taking away any from the old ones. And it does not take special

advertisement. Hanging out his shingle, with a little announcement in the paper mentioning his specialty and background, does the trick. All that matters is that he has something new to offer. The demand for medical and pharmaceutical services is virtually infinite. It stems from the desire for lengthening life, multiplying its pleasures, reducing its pains, and generally strengthening body and soul. The panels make a great deal of this point, the implication being that it is the widening of the medical field and the doctor's shrewd propensity to "sell" ever-new services to the public that is responsible for the vertical expansion of the schemes and the mounting costs. There is, of course, more than a kernel of truth in these charges. But what the panels prefer to ignore is the fact that the services are offered to the public at little or no cost.

Instead, they emphasize that it takes a doctor's signature to be sick and to get "free" services. In compulsory systems, indeed, the signature is almost invariably available for the asking—if not from the first or second physician, then from the third or fourth. There always is a fifth or tenth present who might be willing, unconsciously or otherwise, to walk on ethical tight-ropes. It is a tight-rope from the point of view of the scheme managers, who in turn have to do something about it—to stop the medical tail from wagging the administrative dog.

“Dehumanizing” Medicine



ABUSES go hand in hand with “mechanization” of the patient-doctor relation. Four factors combine to distort that relationship. In different degrees, all four are common to every obligatory scheme:

first, the attempt of the beneficiaries to make the most of the schemes, thereby overstraining the medical and auxiliary services;

second, the comparatively low pay of the medical personnel and the keen competition among its members;

third, the necessity of bureaucratic controls over the personnel of the service as well as its beneficiaries, and

fourth, the reaction of the medical practice to the impact of these conditions.

MEDICAL PRACTICE UNDER INFLATED DEMAND

Of course, abuses, such as overcharging the patients, occur on a free medical market. But competition and the pressure of public opinion help to eliminate them or at least to keep them within bounds. Under compulsion, on the other hand, motive-forces come into operation which create and perpetuate abuses. They in turn lead into modifying the medical practice in a direction highly unfavorable to its very objective.

The schemes operate essentially as permanent price-fixing devices of an extraordinary kind. Disregarding some exceptions, the prices of a broad range of valuable goods and services are fixed at or near zero. In addition, cash benefits are forthcoming, provided the doctor is understanding or conniv-

ing, if he is not being fooled. The unavoidable happens. The demand skyrockets, as it would if a department store advertised that all wage earners and salaried people in town, plus their families, and (in Britain) everybody else, might "purchase" to their hearts' desire, and free of charge. Moral exhortations do as little to stop the buying spree as does the fact that payroll deductions, employer contributions, or taxes on the community at large have to pay the bill. Actually, the fact of contributing something may be an incentive to the beneficiary to do more "buying" rather than less, so as to get the maximum equivalent of his or her contribution. The resulting inflation of demand tends to vitiate the purpose of the compulsory system—of the medical function itself.

Unfortunately, no scientific technique exists that would permit one fully to appraise the results of one kind of medical system as against the other—free vs. compulsory systems. But certain tendencies of the latter are evident and have to be pointed out. Appraisal of the former does not belong in the framework of this study.

DOCTORS' REAL DILEMMA The practitioner has been called the patient's servant.¹ His oath binds him to his patient and to no one else. So do or should do his professional ethics and presumably his personal sympathy. To expect any other attitude from him than that of undiluted medical service to those who seek it perverts the meaning of his vocation. What is to be expected is, rather, a natural inclination to please the patient by fulfilling his demands beyond the "necessary" measure, whatever that may be. To serve the panels or the government *against* the patient is as unethical for a doctor as it would be immoral for a lawyer to protect the interests opposed to those of his client.

Moreover, the doctor depends economically on the clientele as any businessman does. On a free market, the quality of his performance, as the patient sees it, and the "personal touch," are supposed to be the prime measure of his reputation. Even there, his refusal to tolerate preconceived medical ideas and to support lay requests is often more intensely resented by the patient than are errors in diagnosis or treatment. In compulsory schemes, the prime interest of the patient is not medical aid per se. With or without it, he wants cash and other benefits

from the health organization. Naturally, the sick person looks at the institution from the one center that occupies his mind. The one who feigns sickness does so, too.

But the problem children of the panels need be neither liars nor frauds. The worst to deal with is the imaginary patient, as indicated before. A prominent German expert (a staunch believer in the compulsory system) formulated it sharply: the patient's "critical ability is more or less reduced. For this reason, he expects from the physician above all a generous handling of his own wishes which he considers basically justified, and the more so the more his sickness is psychologically rather than physiologically determined. The imaginary patients raise the greatest demands, and it is virtually impossible to make them understand that somehow they ought to limit their requests for the sake of the community."²

True, in no scheme is the number of imaginary illnesses estimated above 20 per cent of the total. That alone might be sufficient to block the legitimate medical traffic. But far more important is the imaginary or exaggerated portion in the "normal" patient's real ailment. It is likely to be excessive under a system that in effect puts a premium on being sick—or on being sicker than "necessary." What to do about that is the doctors' real dilemma.

MECHANIZING THE MEDICAL PRACTICE

In Germany, where two generations of experience and debate have helped to destroy illusions, responsible doctors and panel officials—not the neo-liberal politicians and literati—are deeply worried about the results in terms of medical service. Not all patients and doctors are equally affected, of course. But by and large, the general practitioner tends to become a general agent to fill out forms and to distribute medications on a level which is sometimes little short of charlatantry.

Visualize his position. To refuse the patients' requests may or may not be ethical; it is certainly not expedient. They would go to his less scrupulous competitor. Given the very low rate of remuneration and the progressive elimination of private practice, the number of patients is, to use a cliché, his to-be-or-not-to-be question. That number depends on his reputation—in obliging the patient who, under the compulsory system, may

be as much interested in its benefits as in being cured, if not more so.³

An illustration, one among many, is provided by the German panels themselves, which are well aware of the fact that a newly-established general practitioner at once draws away the panel patients from old established ones. The public expects more "generous" response from the newcomer who still has to build up his business. It may be true, too, that the older practitioner already knows his clientele and recognizes at once some of the malingerers and hypochondriacs.

The result is what has been called *doctoring on the conveyor belt*. Overcrowded offices, long waiting by patients, and "quick" service—often two and three minutes only per patient, sometimes by phone in lieu of office appointment—characterize the successful health panel or scheme doctor's office in every compulsory scheme (other than the French-type). The unsuccessful ones, naturally, have more time, but they are compelled to take the old and "unhealthy," the unpleasant and cantankerous whom their luckier colleagues have shaken off.⁴ So, the fewer patients the more work and trouble with each, on top of insufficient remuneration. And financial worries do not increase the professional proficiency.

Typically, the scheme practitioner (outside France) is overworked, due also to the additional strain put on him through the inflated number of visits to patients. The British Medical Association estimates that under the old panel system five consultations and visits had to be counted per year for the average insured. Now, the number of potential patients has doubled, and more of them ask more often for the doctor, which means probably as many as 100 cases per workday for a "successful" practitioner with, say, 3,000 registrants. That many he needs in order to earn an annual net, before taxes, equivalent to \$4,000-\$5,000. The same holds for his German colleague who is called a "panel lion" if he makes that grade. By contrast, the average number of daily consultations and visits of a Parisian doctor who works for the scheme is estimated at 20.

SPECIALISM AND IRRESPONSIBILITY

The general practitioner devotes as much as one-fourth to one-third of his time, depending on the scheme and the number of patients, to bureaucratic transactions: writing out pre-

scriptions, filling in official forms, writing letters to specialists and hospitals, keeping elaborate records and accounts, etc. The combination of time shortage, due to an excessive number of patients and of paper work and the fact that his fee is virtually fixed (except in the French system) results not only in a physical and mental pressure but also in the unavoidable tendency to get rid of the patient. The sooner he or she is switched over to a specialist or to a hospital ward, the less work and responsibility burdens the general practitioner who should be the heart and soul of the profession. Instead, he is in the process of slowly being demoted to the status of an allocating agent, sending patients to pharmacists, specialists, hospitals and sanatoria.

The outcome is that a tendency toward a dangerous and in many ways unproductive sort of specialism rules the governmentalized services (outside France). The danger is that the most important function may be neglected—the diagnosis and treatment of the patient as a personality rather than as a mechanical sum of individual and unconnected diseases. The trend is toward dealing with cases of disease rather than with sick individuals. Overburdening the specialist and the public hospitals, in turn reducing their efficiency as well, is the further consequence. The leaning toward specialism is inherent in modern medicine itself. It is fostered by the popular press, and by the fact that medical education is almost totally monopolized by specialists. Governmentalization tends to make it dominant.

Responsibility toward the patient ceases the moment the practitioner gets rid of him. And the danger is that no one else takes it over. There is virtually no possibility of so-called assessing treatment. Actually, the practitioner loses contact with the patient as soon as the latter is delivered into the hospital or even to the specialist. In the hospitals, in every scheme, the patient's free choice of doctor is suspended. He may call in the family doctor at his own expense, but even then the latter has no power to "interfere." The patient is being treated and operated on by specialists who may know no more about him than his perfunctory case history, if any is available. In the place of a systematic, beginning-to-end, medical guiding and controlling, the compulsory system's emphasis is on specialized performances.

They serve to exhibit results not only of medical but also of great publicity value. But they do not substitute for medical care proper. To make things worse, the more these special services are being provided the more difficult it becomes to obtain them. Where they are being made available totally free of charge and, therefore, politically most effective, the patient has to wait. In June, 1949, when this writer surveyed the situation in London, it took four weeks and more to get a tooth extracted, six weeks for a barium meal X-ray, two to four months' wait for a hospital bed, up to six months for eye glasses, and so forth. But all were available on short notice if paid for in cash. The number of incidents reported involving serious damage to people who had to wait too long was growing. At the same time, sorely needed hospital wards had to be closed due to the lack of nurses, and ward patients even had to perform menial services.

ANTINOMIES OF MEDICAL AUTHORITARIANISM

Governmentalization revolutionizes medicine to the disadvantage of professional standards—of medical results. They depend to a large extent on the trusteeship relation between doctor and patient. That relationship is being uprooted. For one thing, medical secrecy ceases wherever controls are instituted, as they must be sooner or later. Even in the French system, the *caisse* bureaucracy can decipher the doctor's diagnosis by reading between the lines of his prescriptions. Elsewhere, especially also in Britain, he has to disclose every detail to the officials who are not bound by oath to the patient. Confidence in the doctor is not enhanced by this innovation nor by the fact that physicians engaged or retained by the bureaucracy may reverse the practitioner's judgment.

On top of it all, the practitioner tends to lose his independence *vis-a-vis* the patient. Being economically weak, he cannot afford losing clientele. He often cannot afford to contradict the patient, especially in matters in which the latter's material interests—such as keeping out of work—are affected.

Then, there is the burning question of who is "sick" from the technical point of view of the schemes. They all are inclined to consider sickness as a matter of objective symptoms. No proven symptom, no certifiable sickness—is the German panels'

device. Otherwise, any one could come and ask for benefits. A bureaucratic set-up could not operate rationally—without corruption—if it had to leave such important decisions to "arbitrary" judgment. But even the layman knows that subjective symptoms, although in no wise recognizable by instruments and chemistry, may be diagnostically most significant. What then should the doctor do who is bound by oath to serve the patient and by contract to obey the rules of the panel—and who wants to earn money, too?

As a bureaucratic set-up, medical compulsion operates on the implied assumption that diseases are objective, well-defined phenomena, and that prefabricated techniques to cure them are at the profession's disposal. In reality, not only have most diseases psychological implications, but even many purely physiological problems are highly controversial. Medical judgment must be subjective to a substantial degree. It does not take conspiracy between patient and doctor to move the latter toward generous allowances to the benefit of the former. By professional standards, as well as under the incentive of his own interests, the physician is likely to give way to the demands for paid vacations, for more than essential medications, for rests in hospitals and sanatoria, for special treatments the patient urges. Giving way to all claims and signing a certificate are, of course, the easiest escape from responsibility.

As a matter of fact, the mechanism of compulsion compels the practitioner to fulfill the patients' request to the limit, whether rational or not, which is one way the former mitigates the ill effects of his diluted practice on the latter. Since the doctoring is likely to be superficial, putting it mildly, due to lack of time and incentive, the compensation of the patient in the form of gratuities—at the scheme's expense—is the doctor's moral and material relief. Indeed, the trouble with compulsory medicine is not entirely that it gives free rein to doctors who do not take their responsibility seriously and are satisfied with "quick" diagnoses and simplified medications on the purely instrumental and chemical level. It is the conscientious doctor who is in danger of being driven into mechanizing his professional work. He cannot declare a patient healthy and risk the consequences of error when he has no time to diagnose properly. The safe thing is to accept, so far as possible, the scheme patient's own diagnosis or to make a "temporary" one,

and to expedite him further, hoping for the best, as experienced panel practitioners of several countries assured this writer. The patient, of course, is the one who takes the ultimate punishment.

WHAT ABOUT THE PATIENT? The more medical science progresses, the more conscious it becomes of the tremendous complexities of what is called "sickness."

That the treatment of patients on the pattern of factory production cannot fulfill scientific requirements should be obvious. (Note that in nationalized accident insurance, in which substantial compensation is at stake, thorough-going and repeated medical examinations are mandatory, while they tend to be the exception in compulsory health care of every denomination.) The few minutes the average scheme doctor can spare for the average patient cannot do justice to the psychological implications of the case, to say nothing of such ultra-modern requirements as the proper consideration of the latter's occupational and family backgrounds and his hereditary circumstances, or even to weigh properly his frequent "exaggerations, under-statements and distortions."⁵

Nor is the question one of curative medicine alone. The family doctor's role in providing preventive medicine hardly can be exaggerated. Quick diagnoses, usually without case history, and even with the best of specialized clinical treatment, may produce curative results but never can substitute for the long-run counsel and guidance of the practitioner in avoiding or minimizing illness.⁶

Comparatively poor medicine but rich subsidies tend to be the net result of governmentalized health care. In fact, it "cares" for a minority, one privileged by its own insistence or by sheer accident, rather than for the health of the masses. It leaves a large sector of those in real need often without a reasonable minimum of medical protection. The cases of actual damage done by neglect or through lack of facilities never could be counted. Such cases may occur in a free medical economy, too, and to an unknown extent; but there the facilities are not overstrained to any similar degree; remedy is possible, disregarding exceptional situations.

Under compulsion the medical services tend to be progressively *dehumanized*, to use the descriptive term coined by an eminent student (and advocate!) of social security, Monsieur Georges de Lagarde. Small wonder that the doctors' dissatisfaction bursts into the open in all countries concerned. To quote one characteristic emotional outburst: "95 per cent of all patients entering a doctor's surgery (office)," wrote an English practitioner in 1943, under the comparatively restrained Lloyd George system, "demand some form of certificate. The primary function of a general practitioner is no longer medicine, either preventive or curative, but merely the writing out of certificates. And his most important concern is that the certificate shall be a safe one, that is, one that will satisfy the patient, satisfy his own tattered conscience and . . . keep him out of the clutches of the General Medical Council."⁷ And he is overloaded with forms myriad and formidable. Lately, the number of British "forms" has multiplied further.

**QUANTITY vs.
QUALITY OF
SERVICE**

Scheme administrations and their following argue that we should be patient and let the system develop its potentialities. Of course, the same admonishment—for patience—may be invoked in favor of the free medical market, too.

But the objective student is faced with an even more serious question, the discussion of which is blurred usually by emotions. Is it not preferable to provide the "needy" (who need to be defined) with some medical service, be it one that is admittedly far from satisfactory, rather than to let them drift "helplessly" (whatever that means)? Undoubtedly, the compulsory systems imply that in terms of doctors-per-minute, of drugs-per-ounce, of appliances-per-piece, of teeth-pulled-per-person, etc. more is being put at the public's disposal than would have been offered in the same country and at the same time if all those services had to be acquired at their market prices. If so, comparison of a free vs. a compulsory medical market should result in favor of the latter—in purely quantitative terms. If it were possible to measure those services by reducing them to multiples of a homogeneous unit of energy, let us call it an "erg med.," the compulsory systems should be

found producing a much larger number of such units per capita than the free systems do under the same or similar circumstances.

But it is equally certain that the unit of service procurable and actually procured under a free system must be of higher quality. The evidence is overwhelming. For one thing, a doctor who sees 20 or 30 patients a day is likely to do better with each of them than one who sees 80 or 100. That leaves us in a quandary: What kind of medicine do we consider desirable—one that produces the maximum number of per capita ergs med., or the other that gives the highest quality of service under the given conditions of the respective country?

What I am trying to say is that not all is light on the one side and darkness on the other. The free medical market may produce marvels, but they may or may not be accessible to the "submarginal" patient. Governmentalization is supposed to take care of that. On the other hand, the quantitative progress achieved in compulsory systems should be weighed in the light of the qualitative deterioration that accompanies it. Such weighing can take place, however, only in the spirit of cold-blooded realistic discussion, not in the atmosphere of political oratory under which the controversy labors in virtually every country. To promise *adequate* health care, as the proponents of compulsion do, means to use the words in an irresponsible careless fashion. All they can promise honestly and knowingly is some care for every one, including those who (allegedly) would have none or too little, but accompanied by a qualitative lowering of the level of medical service for the vast majority.

MEDICO-SOCIOLOGICAL ARGUMENTS However, it should be remembered that even the quantitative gain may turn out to be illusory if the demand for medical services expands faster than the supply of competent doctors and nurses, of hospital beds and equipment, etc., can be increased. But that is exactly what happens when the attempt is made to satisfy the demand at a greatly reduced cost or at no cost to the recipient. Then, new submarginal patients emerge: patients who cannot get what they are entitled to, in the place of those who could not pay for what they needed.

That still leaves another medico-sociological argument in favor of governmentalization: the argument that at least it

awakens the public's interest in, and hope for, health care. It does that, provided the interest and the hope are not checked by sharp "deductibles," discriminatory physical controls and the disappointing lack of promised facilities. Even so, the importance of making the public conscious of its own need for medical care should not be deprecated. The inducement offered might lead to the early discovery of incipient diseases, diabetes and tuberculosis in particular. In this respect, the compulsory systems may have an accomplishment to their historical credit. But so have the free clinics, which under free systems always have been available to the poverty-stricken patient. At any rate, the same result might be attained, if somewhat more slowly, at much less cost to society.

"Since we Nazis are convinced that we are right, we cannot tolerate anybody who contends that he is right. For if he too is right, he must be a Nazi, or, if he is not a Nazi, he simply is not right." Dr. Goebbels.

C H A P T E R

T H I R T E E N

The Futility of "Physical" Controls

THE shortcomings and abuses of the compulsory system mean that the public is endangered by deterioration of the medical services and that the costs of providing them are threatened with sky-rocketing. For both reasons, controls are needed.

SUBSTITUTES FOR THE PRICE MECHANISM

The most effective control is the price mechanism, of course. But that is eliminated from the outset. Common sense would indicate that at least some degree of control should be applied, by way of pricing the benefits it distributes, if only in the form of deductibles. They are applied generally in the French and Belgian schemes, except in distress cases and long sicknesses. The panels in Switzerland collect 10% to 20% deductibles from the beneficiary who himself does not pay for the services. (Swiss panel managers get a commission on what they collect.) The Swedish free panels shift 25% of the expenses onto the patient. Other countries, except Britain under Bevan, use the device for restraining the demand for one kind of service or another.¹

But the deductibles do not accomplish their purpose. To be politically expedient they have to be too small. And experience shows that small deductibles create a tendency on the part of the beneficiaries to compensate for their "loss" in some service by trying to grasp more in some other. What is even worse, the technique of partial charges violates the basic principle of medical security: to relieve the financially weak patient. He has to pay his share and may not be able to do so.

Nor do the deductibles correct the basic difficulties of the system. Once the patient has paid the charge for his sickness ticket or his share in the doctor's fee, there is nothing to restrain him from staying sick as long as the doctor agrees—provided he does agree—which is what happens for reasons discussed in the foregoing chapters. The French system tries to check this abuse by restricting the validity of the patient's first two sickness certificates to eight days each. Result: the first two certificates are made out, as a common practice, for eight days each.

Another planned substitute for the "invisible hand" of the price mechanism consists in refusing to pay cash benefits for the first few days—as a rule three days. Even the British free-for-all plan retains this delay-device. The delay is four days in Spain, five in Greece, six in Australia, and seven in the British (1) ruled zone of Germany. But it is negative in New Zealand where cash benefits may be dated back to the first of the month. The imposition of a waiting period has some value as a deterrent, but again, it may induce the patient to stay sick longer than he would otherwise so as to "get something out of it."

From Bismarck to Bevan, health politicians realize that only a system that does not charge the patient is a full-fledged political asset to its promoters. Especially so, when the beneficiaries share in the payroll taxes which finance the scheme—when they feel that they have "paid" in advance.

That leaves physical controls as the way out, just as rationing is the logical sequel to price fixing. And both have to be enforced by police methods.

PHYSICAL CONTROL —BY CHICANERY

Physical restraints on the demand for medical services are common to almost every scheme. In the panel systems, they may start at the outset: when the patient applies for a sick ticket. This should be a pure formality. But the trouble of going repeatedly to the panel office, having the proper papers prepared and being kept waiting each time, may be a mild deterrent. At any rate, the Austrian panel bureaucracy has developed quite a technique of deliberate *chicanery* and time-wasting so as to deter the would-be pa-

tients or to test their patience. The pattern finds imitators in other bureaucracies. In France and Belgium, red-tape in collecting the bills which the patients have paid themselves helps to exasperate the public and to save money for the panels. In other schemes, over-crowded doctors' offices keep some patients away or drive them into becoming paying customers—a sort of a black market in doctors.

POLICING BY GENDARMES In a French provincial city, the leading *caisse* official made the point: the Frenchman fears nothing but the gendarme. The point was that inspectors are needed to check on the patients, lest they "cheat." The point holds beyond France. The method originated in Germany, where for a long time the panels have been keeping on their payrolls agents to check whether the sick stay in their homes and in bed, if that was the doctor's order, or do house or garden work, or take a walk. Whether German or French, the patient need not admit the agent into his home; but then, he loses automatically his current claim on benefits. In Belgium, each "violation," including drunkenness, is "punished" by the loss of rights on health care for specified periods. In fact, a special plain clothes police is being developed, an extra-legal one, that scarcely could do without spying and snooping. How could it check but with the aid of neighbors and informers?

The respective scheme administrations are proud of this technique and its success, admitting its inability to cope with short maladies. Obviously, it takes time to put the agents into motion when their number must be limited for financial reasons alone. No panel can afford more than a few. Britain is one of the countries where such policing is not as yet applied. But it would be remarkable if the elaborate controlling, checking, policing and snooping used to supervise price-fixing, material allocation, and similar regulations should not be extended to the medical field. If the Minister of Food (Mr. Strachey, a former communist) has his private police force, why should the far more powerful (and equally radical) Minister of Health be worse off?

Note, in passing, that drunkenness is no sickness in at least three schemes, the German, Danish and Belgian, which raises a fine point in medical administration. But perfect silence reigns

on this subject in the innumerable rules, regulations, ordinances and circulars of the French and British schemes. In both, alcoholism constitutes a heavy item of the total cost.

It goes without saying that police controls are most fully developed and most ruthlessly applied by the Soviets. "All operations in connection with social insurance must be carried out in complete conformity with the prescribed budget." The July, 1937, *Bulletin of Central Committee of Communist Party*, announced that persons infringing upon the "plans" of the social insurance fund "will be subject to serious punishment in a criminal sense." M. Gordon (*Workers Before and After Lenin*, p. 304), who has collected the data on the social practices of the Soviets in the 1930's, further points out: "To make certain that the social insurance physicians did not show undue sympathy for 'loafers' and 'idlers' they were instructed not to exceed the prescribed routine in their attendance upon patients. According to the regulations, the doctor has the right to issue tickets of admission to the hospital for not more than three days at any one time; in case of complications or a crippling accident, for not more than ten days. Permission to remain in the hospital for more than ten days can only be granted on the authority of the chief of the medical staff or advisory commission."

CONTROLLING THE DRUG "SPECIALS"

The Austrian panels have initiated a technique of controlling the pharmaceutical expenses. The so-called specials—the new, expensive and specific drugs—are one item in prescriptions that make the scheme officials' hair stand on end: hormones, salvarsans, vitamins, insulins, sulfa drugs, penicillins, streptomycins, other antibiotics, carbazones, amino acids, antihistaminics, etc. New ones come up almost weekly and are especially expensive while they are new. But just then they are fashionable and most attractive to the experimentally-minded doctors—most convenient and time-saving, too, since they imply less mental effort in diagnosis than carefully considered prescriptions. They are most in demand by the public itself, thanks to the wide publicity they usually enjoy (which holds also for the popular laxatives). As a matter of fact, many scheme patients consider themselves poorly treated if they do not get three or four medicaments prescribed at each visit—

and judge the doctor accordingly. What the Austrians started in 1928, the rule of the *economic prescription*, has had medical rather than economic significance. A list of authorized specials was drawn up, and the use of those unlisted forbidden. Obviously, the doctors' hands thereby were bound. But the financial result has been virtually nil.

LIMITING

PRESCRIPTIONS

Financially more effective, and medically far more damaging, is the German method of so-called *regular prescriptions*. After decades of bickering about what the doctor might or might not prescribe, his freedom to prescribe was finally established in 1935—under Hitler! It turned out to be a Hitlerite type of freedom. The general practitioner is permitted to prescribe each quarter up to a total of 4.50 marks per patient, equivalent before the last war to less than \$2.00 (\$1.00 by now). If one patient gets less, that much more is available for some other, and vice versa. Similarly, specialists have their "regular" quarterly pharmacy allowances (*regelbetrag*) per patient: 3.50 marks for surgeons, 4.75 marks for dermatologists, etc. The insane fare best: they may enjoy 5.50 marks worth of chemicals.

If the result is insufficient medication, that is just too bad. Naturally, at the beginning of the quarter, the doctor is more generous and may give way to demands. By the end, he will be cutting corners. Constantly, he will be in conflict with his patients and with his own conscience as to what is necessary and permissible. He also will have a nice bookkeeping job on hand, checking on every one of the remedies prescribed to each and every patient. If he makes a mistake, he is liable for the excess, unless he obtains the O.K. of panel officials to whom the compound designations may be so many Greek words (but they learn fast).

Sooner or later, every scheme is impelled to economize on the pharmacists' bills—cutting down on the doctors' freedom in writing prescriptions. The Austrian device of "filtering" the special pharmaceuticals is a popular one with the bureaucracies. In most countries, the prescribing of expensive medicaments is dependent on advance consent of the lay officials or of governmentally engaged scheme doctors.

In France, in 1935, under the obligatory panel system of Laval, the attempt was made to reduce the drug demand by hiking the deductible for the more expensive compounds. The more expensive the drug, the higher was the percentage charged to the patient, an obvious injustice. Also, it complicated the liquidation of the bills and forced the patients to wait longer.² Presently, the attempt is under way to eliminate the "unnecessary" specialties from the list of those permissible. And mind you, the medical quality of the specialties is not in question. That has to be tested by competent research organizations before the specialty is listed. What is at stake is merely to save money by reducing the facilities' abuse in which the patients and their doctors apparently indulge.

For the same reason, the "refill" of prescriptions is taboo or under strict limitations in almost every scheme. So, the patient either buys larger amounts or has to run to the doctor for each fresh bottle of laxative. In either case the total cost of his health care is enhanced accordingly. The generous Mr. Bevan chose a new departure. In his scheme, there is no limit set to refill orders, cost what that may. But on the other hand, the slightest repair of a Britisher's eye glasses calls for certification by an ophthalmologist.

PHARMACISTS UNDER AUTHORITARIAN RULE

What about the position of the pharmacists in compulsory systems? They always join the schemes placidly—especially those who do less than average business. The fact is that in every scheme, pharmaceutical expenses tend to rise. Usually, they amount to 20% to 25% of the total cost. The administrations are not quite unjustly suspicious that this is more than would be the case if it were not for the doctors holding the patients' and perhaps also the pharmacists' hands. It is more than mere suspicion in Germany that individual panel doctors have or have had close ties with drug producers.

Almost invariably, prices of common drugs or gross profit margins are fixed in national pharmacopoeias or by the panels. Generally, this meticulous and time-absorbing process³ results in severe profit reductions. Drug producers rather than drug-gists are often victimized, especially at times of price inflations, by policies reminiscent of our O.P.A. and Fair Trade regulations. Moreover, pharmacists' organizations are en-

gaged in endless accounting and elaborate bargaining procedures with the schemes. The former cost each member of the trade about 2% of his gross intake. In this respect, France is again the exception. Thanks to the system of "direct" payment by the customer, who then has to collect at the *caisse*, the pharmacist like the doctor in France is saved the trouble and cost of additional bookkeeping and of continuous collective dealings with the scheme.

When compulsion is introduced or greatly expanded, the drug business booms. Governmentally paid British drug sales jumped by about 50% in the First Year of Mr. Bevan who has stopped the doctors' dispensing—practically ruining the grossly underpaid rural doctors—so as to bribe the chemists into cooperation. Not only more medicine is being prescribed for more people but also more expensive types of medicine. (See Chapter VI.) But private sales decline. They did so in Germany between 1913 and 1928, from 65% to 51% of total sales. The decline must be much sharper currently in Britain. There, a minority of chemists are losing business, while those in factory areas are gaining. For all of them, the honeymoon with the scheme never lasts.

COMPETING SELLERS VS. BUYING MONOPOLY

The auxiliary industry, like the main profession, finds itself faced with an overwhelming monopoly backed by the state. No trade association or cartel can match that power, least of all a competitive industry. The German panels have forced down the pharmacists' throats a 7% all-round cut on the sales' gross of common drugs, plus extra rebates. Other bureaucracies resort to arms-length bargaining in which the monopolistic buyer is likely to get the better deal.

Cheaper prices for drugs and appliances would be an advantage from the consumer point of view if it were not for drawbacks. The pharmacies try to take out on the private patients what they lose on the governmentalized prescriptions. In Switzerland they are encouraged to do so. In any case, the tendency to substitute cheaper ingredients obtains; to use *autsimile* recipes, next best to those prescribed; or to sell in "bulk": 50 aspirins where 10 would do ("we are out of smaller packages"). Who will check each time whether the iodine-

calcium solution is 10% or 5%? The monopolist's chiseling is countered in kind, legally or otherwise. There is little economy achieved, but the seed of added troubles is sown.

Additional controls are the "pay-off." Pharmacists' organizations are supposed to police their own members. Governmental inspectors examine and test the formulas and their handling. Everywhere, the bureaucracy exerts pressure to reduce prescription fees, to use cheaper compounds, to eliminate proprietary drugs or trade name brands, and to substitute as much as possible their ingredients, this to the detriment of manufacturers and of private research activities. "Averaging up" of prescriptions is another device to cut down on the profits of the chemist who has no recourse to the courts.

Except in France, where the patient pays directly, the pharmacists have to wait as much as six months to get their money, thus tying up their capital and losing interest. What that may lead to was graphically illustrated in Belgium. Last May, the central *fonds national d'assurance maladie-invalidité* notified the pharmacists' organization that it was unable to balance the accounts for the first part of the year. In other words, when worst comes to worst, the scheme defaults on the bills for medicaments and appliances. The position of the auxiliary trade in Belgium is especially precarious because of the large number of competitors: some 3,300 shops in a country with ten million population which is more per capita than anywhere else in Europe.

The conflict between the Belgian scheme and the apothecaries has a further and most instructive aspect. One by one, the panels or their federations either open their own outlets or make special deals with individual pharmacists who become their official outlets. The majority of the trade thus risks being gradually squeezed out of business. Nationalization of the trade, step by step, is the prospect. That certainly is one of the expressed or implied ideals of Political Medicine. It is implied also in the new British scheme's promise to open government-owned medical centers which are to include pharmacies. The recently (October 1949) reelected socialist regime of Norway is set on introducing a governmental monopoly of the importation and distribution of drugs.

WHAT TO DO ABOUT HOSPITALS?

Most schemes do not own their own hospitals, although many of them experiment with financing panel sanatoria, children's homes, etc. In Russia all, in Britain the bulk of them, are nationalized. On the Continent, they are predominantly municipal or charitable institutions, while a substantial number operates as private enterprises. In Germany and Central Europe, the leading clinics are parts of the governmental but autonomous universities. Most schemes have contractual arrangements with the public institutions, sometimes even with the private ones, to which they send their patients and pay the current price. The patients are placed in a regular ward, usually designated as third class, and are treated exactly as the rest, which means the poor relief level. They are no better off than they used to be before compulsion, at which time they had to pay for hospital care only if they had the means to do so. Often they are worse off, due to overcrowding. In most countries—not in Britain—scheme patients can transfer to the second class by paying the difference in price.

Under the compulsory plan, hospitals, whether nationalized or not, get a tremendous influx of patients. People who normally would stay at home, even in maternity cases, take advantage of the scheme. They do so especially under the new "security" schemes which are far more liberal than the "insurance" plans of old. The management of a French provincial hospital told this writer that before the 1945 "reform" they practically never had farmers' wives as lying-in guests. Doctors unload their patients in proportions as never before. Sick children are sent in so as to save the family the trouble of caring for, and the doctor (under the capitation system) of visiting, them at home. The adverse moral and even medical effects of over-hospitalization have been much discussed in the respective countries.

In most schemes, hospital costs rise faster than any others, excepting those for dental care. (See Chapters VI and VII.) The compulsory plans are largely responsible for this: they provide "easy money" that permits the public hospitals to carry on in an irresponsible fashion. In France as well as in Britain—the two western countries in which health security has fully replaced health insurance—public wards charge more

per bed than do most of the private nursing homes. This is remarkable in view of the fact that the latter are less crowded, offer better service and pay their own employees higher salaries than do the former. Actually, the exploitation and low pay of nurses and other auxiliary personnel in many European public hospitals are appalling. As one example, the remarkably well-kept municipal hospital of Chartres, France, has a separate building for infectious cases of all kinds. When I visited it, fifty-odd patients were served by one single nun—day and night. The average monthly pay of trained nurses amounts to the equivalent of less than \$80 in England and to about \$35 in France, but nuns receive a monthly \$6 or so. Small wonder that shortage of qualified personnel plagues the hospitals, in spite of a substantial supply from religious orders. In Paris, untrained servants do much of the "nursing."

HOSPITAL

NATIONALIZATION

In Britain, under Bevan, medical appointments in the nationalized hospitals have been "promoted" into the sphere of politics. Internally, hospital managements so far are unfettered, but with their current costs running out of hand. In return for expropriating the bulk of the hospitals' funds, and in the face of solemn promises to expand the facilities of which they are in dire need, the government has greatly curtailed, by 9½ million pounds, the modest capital expenditure program of the hospitals, for 1949-50, even in cases where such expenditure would have resulted in reducing the operating costs.⁴ On the Continent, the scheme administrators have no direct influence on the hospital systems. In France, they watch eagerly the latter's records in low efficiency and high costs, especially under the *assistance publique* of Paris (that "lost" one day the linen reserve of 90 establishments): a daily ward rate per bed of \$5 to \$7, or double the cost of a single room and meals in an average Parisian hotel. In the meantime, the panels send their control-doctors into the hospitals to check whether or not the panel patients are over-staying.⁵

When the government takes over the hospitals, their management is soon snarled up in red tape. Reports from New Zealand tell the story of endless investigations and delays on every detail, such as acquiring vacuum cleaners, repairing

roofs, etc. Similar difficulties begin to show up under nationalization in Britain.

BUREAUCRATS AS MEDICAL EXPERTS

The last word in control is—controlling the doctor directly. Almost all methods enumerated so far imply just that, if only by curtailing his prescriptions. But the problem is to supervise his entire practice so as to eliminate irregular certifications. To do so, Continental bureaucrats (outside France) have appointed themselves as medical experts who argue with the practitioners about the feasibility of or need for keeping the patient in bed, providing hydrotherapeutic or ultra-violet ray treatment, putting a diabetic on insulin or merely on a diet, etc.

Some of the control methods of the lay bureaucracy have been mentioned. A most "subtle" technique is the *statistical*. The big panels in Switzerland, as an example, keep elaborate books in which each doctor's performances are itemized and summed up month for month. A statistical average is drawn from the number of consultations, house visits, therapeutic treatments, per patient, as well as for pharmaceutical and hospital bills, etc. The doctors whose bills rise above the average are called on the carpet. If they do not conform to the averages, they risk losing the privilege of treating panel patients. That such pressure to conform is not to the benefit of the patients has been emphasized by no less an authority than Dr. Saxer, the president of the Swiss government's Social Security Department in Berne, in conversation with this writer.

This goes to show that not all government officials are "bureaucrats." The same gentleman expressed his frank satisfaction over the fact that the Swiss people had refused, by referendum, to submit to a federal compulsory scheme.

DOCTORING THE DOCTORS Obviously, only a doctor can technically "control" another doctor.

Every compulsory set-up develops a hierarchy of control doctors. The total number of permanent and temporary "trustee doctors" (*vertrauens-aerzte*) in Western Germany is estimated to be between 6,000 and 7,000. They are not supposed to interfere with the practicing doctor but "only" to decide on "material" expenses, hospitalization and cash benefits in particular—the things that matter.

More than 700 doctors are in France at present on permanent, official appointments. If the practitioner and the official doctor disagree, independent specialists are called in to arbitrate. The officially engaged *médecin conseiller* has to concur with the private *médecin traitant* in every case of long malady, and on such other occasions as the panel management may deem fit. The patient's doctor is under the control of another doctor on whose loyalty the scheme is dependent. The conflict of fiscal vs. medical interests was highlighted last April by the widely publicized case of a "non-curable" French worker: physicians in charge proposed to carry on treating a fractured leg, but the doctors of the *caisse* insisted on amputation to save the cost of a long treatment. The patient's suicide ended the controversy.⁶

CONTROL OVER DENTISTS All schemes keep the dentists under control. They could wreck the Treasury, as the late Professor A. Epstein, a foremost advocate of social security in this country, has put it, commenting on a study of the potential cost in providing dental care.⁷ Under the Bevan scheme, the dentists have to ask permission from a Dental Estimate Board for every single operation. This Board scrutinizes every instance involving major dental appliances, about one-third of all cases. It passes judgment on some 30,000 daily applications, employing 700 clerks, 8 dentists among them. Obviously, the control can not be but nominal. The results are so far a substantial delay in dental care but no noticeable check on its total cost. On the Continent, deductibles, the substitutes for the price mechanism, produce more savings and less bureaucratic waste than is the case under the British technique.

The German method of restricting the expenditure on dental care to a limited sum per patient each year—in Holland and Denmark to a nominal amount—predominates in Northern and Central Europe. In Hungary, the dentist's service costs nothing, but the patient has to pay the full price of all materials used in his mouth. The French and Belgian practice consists in leaving the decision on each dental case that involves a major bill to the local panel, that argues it out with the patient, while smaller bills are reimbursed, minus the usual 20% deduction.

"I discover in myself something elemental and primitive: a reaction against world data; a refusal to accept any sort of objectivity such as the slavery of man; and the opposition of the freedom of the spirit to the compulsion of the world, to violence, and to compliancy." Nicolas Berdjaev, Slavery and Freedom (1944).

C H A P T E R

F O U R T E E N

Power Politics in Compulsory Medicine

W

ASTE, corruption, and bad medical practices are at home to a greater or lesser extent in virtually every compulsory system. The conclusive proof of their omnipresence is the fact that the schemes have to fall back on a multiplicity of unpopular and expensive controls. They tend to increase with the age of the schemes and with their expansion. The systems function the more smoothly the less broad they are in scope and the more limited are the benefits. The nearer the organization is to the comparatively free, competitive and moderately sized panel, as in Switzerland—the less the wear and tear and the less expensive are the controls.

CORRUPTION—A SLOW PROCESS

Most schemes still are partial or limited experiments. That goes a long way to explain why they do not arouse the public. But since World War II, the trend is apparent toward making them as comprehensive as is politically feasible. Even so, it takes time before the effects become virulent. The remarkable thing is not that the comprehensive schemes work badly, but that they work as well as they do. Undeniably, they provide a great deal of vital service to a great many people. If they are not becoming the hotbeds of charlatans, cheaters, malingerers, hypochondriacs and other parasites, if they fulfill their destiny, more or less, it is thanks to the inherent decency of the human element—patients, doctors and panel officials—and to the rational responses by which human nature helps to alleviate the evil effects of misconceived political institutions.

It takes time to teach civilized peoples to resort to petty, fraudulent tricks. But there are "smart" ones around who function as catalysts in the process of demoralization, slow as that process may be. The over-crowded waiting rooms of doctors, infirmaries and panel bureaus, the hospital wards filled beyond capacity, fulfill the kind of "educational" function that do houses of correction: the uninhibited braggarts tell their story of getting away with this or that. How often the practitioners themselves oblige by "practical" advice, be it to win customers or to spite the administration, no one knows. Druggists, too, may be inclined to be "helpful" if only by advising the paying client to get on the governmental gravy train. Controlling and policing help to dampen the abuses. However, new "black markets" crop up when old ones close, and the irritation the controls engender tends to burst into fresh devices to circumvent them.

BASIC PROBLEMS OF MANAGEMENT

The dire fact is that physical controls are needed in lieu of the scrapped price mechanism. But to be truly effective they would have to be wholly inexpedient. One of the dilemmas that arises is the choice between quick expedition and "effectiveness" in controls. Expedition of each case facilitates administration, saves a great deal of bureaucratic expense, relieves the doctor and pleases the customer. But then, incisive physical controls are out of the question. They are clumsy and costly, the more so the more effective they are supposed to be. They stymie the profession by red-tape and exasperate the patient. Briefly, the choice is between two evils. One is a great deal of intervention—in the forlorn hope that it will keep out abuses and corruption—at the price of high administrative costs and of interferences with the very purpose of the scheme. The alternative is an easy-going and fast-working bureaucracy—slowed down by the onrush of "cases"—with sky-rocketing abuses and the wholesale fabrication of medical certificates.

Scheme administrations are confronted with a force as strong as human nature itself: the self-interest of all concerned, patients and doctors (sometimes also employers) combined. Their silent "collusion" can not be halted by extraneous checks and interferences, however costly and bureaucratic. The patients want to draw maximum benefits, and the doctors

are impelled to grant all, or most of all, that is wanted. What can be done about that—short of raising deductibles so high (as the French did in the late 1930's) as to eliminate the health "security" of the poor?

INTRA-PROFESSIONAL POLITICS Bevan has solved the problem in his own fashion. The cost and responsibility of control are laid largely on the practitioner. He is "required to keep records of the illness of his (public) patients, and of his treatment of them in such form as the Minister may from time to time determine." He must forward the records to a predominantly lay body, the Local Executive Council, when called upon to do so. They must be accessible for inspection and supervision by a District Medical Officer who is appointed by the Minister. This Officer is entitled also to any clinical information he may request. Needless to say, as Sir (Doctor) Ernest Graham-Little has pointed out, that medical secrecy, to which the doctor is bound by his oath, has been completely suspended. He is being forced to break that oath. Also, unmitigated control by bureaucratized colleagues, with no parallel anywhere, excepting Russia, hangs over his head like the sword of Damocles. But even the Soviets do not burden their doctors with a similar volume of time-consuming red tape.

So far, the control over doctors by doctors is more of a threat than a reality in Britain. The reality is the paper work which burdens the practitioner. But one interesting thing about this British method is its punitive character. On the Continent, the practitioner is being checked and perhaps over-ruled. Punitive measures are exceptional. In the British system, he is threatened by penal clauses (Section 35 of the Act) if he has made a mistake, i.e., if he has violated any of the innumerable regulations, even if no "fraud" whatsoever is involved. Little as such punishment is applied so far—the Ministry still is short of personnel—an example is illuminating. An ophthalmologist who acceded to the patient's desire for rimless glasses was not only reprimanded but actually threatened with expulsion from the scheme. And he had no recourse to the Courts. The patients are not under physical controls of any sort, as they are on the Continent, and they may bring their complaints before local organizations and from them to the government agencies.

There is no channel at all through which the doctor can complain against the patient. As a matter of fact, if he refuses to treat one the government might force him to accept the applicant.¹

On the Continent, the official has much less power over the practitioner, although the latter is more often harassed by the former. The French practitioner enjoys more independence than his colleagues elsewhere, which should not be surprising. Even he, however, has to "face the music" but can demand that a "neutral" specialist pass final judgment on the case. The result is that in the provinces the "neutral" doctor decides seemingly in 100% of the cases in favor of the practitioner—who sends him the patients. In Paris, where usually an outstanding medical authority is called in—one who is more interested in being called by the panel than in being supplied with patients through the practitioner—90% or more of the cases are decided in favor of the panel. In any case, in France, as in Germany and most Continental countries, disciplinary action against panel physicians can be taken only through their own professional organizations.

The intervention by official doctors or other experts is highly desirable when called for by the patient and/or the practitioner. But then, the "control" should be medical, for the benefit of the patient, rather than policing, for avoidance or detection of fraud. As it is, the constant threat of interference from "above" means more than a mere irritation to doctors and patients. True, it might help to alleviate glaring abuse. How much, is extremely doubtful in view of the size of the task. Technically and financially, it is not possible to scrutinize with reasonable efficiency more than a very moderate fraction of all cases. The cost of doing a more thorough job is absolutely prohibitive. In 1947, the primary panel of the departments *Seine* and *Seine et Oise*, in Paris, handled a total of 7,000,000 dossiers. Of these, 900,000, or 15%, passed through the medical control, but only one-half of them had actually been scrutinized to any extent by official physicians.

What, then, does the medical control over doctors (and patients) actually accomplish? This much is certain: the practitioner has to turn into an expert in administrative procedure. The laws, regulations, official and semi-official advice and announcements, etc., to say nothing of their manifold

technical interpretations, are complex and voluminous. They constitute a legalistic maze in which he must not let himself be caught. Small wonder that German medical schools have under consideration the establishment of chairs for the teaching of the legal aspects of compulsory sickness insurance.

LIMITING THE CHOICE OF DOCTORS

The conflict between the scheme administrators and their official doctors on the one side and the scheme practitioners and their patients on the other is permanent and irrepressible. It is the conflict between two fundamentally opposed interests. The latter tries to siphon from the scheme as much as possible; the former wants to release as little as possible so as to protect the scheme against bankruptcy. The cooperation or conspiracy between the practitioners and patients is irrepressible, too, as long as the patient can choose among doctors, thus forcing them to compete with one another for the favor of the patient. Free competition among doctors is incompatible with the compulsory system. It might be eliminated in one of two ways.

One way consists in stopping the patient from "shopping" around for doctors. Narrowly limiting the number of eligible doctors, as in Denmark, does the trick more or less. Indirectly and to a moderate extent the same effect is brought about by some form of temporary registration. In Germany, the insured has to obtain from his panel in each calendar quarter a sickness ticket which he delivers to the physician of his choice. The ticket is valid for that particular quarter during which he cannot go to another doctor unless he acquires a new ticket from the panel. As a rule, he "stays put" for the rest of the quarter. In Holland he is restricted to one practitioner for half a year; in Britain he registers with one doctor for a whole year. In either instance switching doctors is possible within the time limits but it is somewhat inhibited, especially so in Holland.

NATIONALIZATION— THE ULTIMATE OUTCOME

Of course, this left-handed little device to solve the fundamental illogic of the compulsory system is as futile as are other physical controls, singly and collectively. The illogic consists in throwing open

the medical services to an unbridled demand, on the naive assumption that it would not go beyond what is absolutely necessary. Only one effective solution for the problem exists. Depriving the patient of free choice among doctors would stamp out collusion between the two. This, in effect, is what the claim of leading German "trustee-doctors" amounts to: that they should be consulted in *every* case involving absenteeism.

That means one thing and one thing only: the nationalization of the profession, bringing it to the status of salaried officials, emasculating its entrepreneurial spirit, and degrading it to a technical adjunct of the bureaucracy.

This has been fully accomplished in Russia, and nearly so in the Satellite countries. There, the doctor has become a government official at a fixed salary. The population of a Barrack Economy has to content itself with barrack doctors who by loyalty and economic interest are tied exclusively to the government. Their job then no longer is to diagnose sickness and to cure it. The job becomes: to diagnose malingering and to keep people from pretending to be sick instead of working. Regimentation of one's most private life turns into a nightmarish reality.

Nationalization of the profession has been partially imposed under the Bevan scheme: so far as the majority of specialists, other than dentists, is concerned. The general practitioners whose overwhelming majority has refused to submit are being squeezed into economic dependency. The final outcome, if the squeeze continues, cannot be doubtful. The doctor's freedom to choose the location of his practice is already lost. In Belgium, Austria and elsewhere the same objective is being pursued by "competitive" methods: official polyclinics and ambulatoria serve to displace the practitioner step by step. Scheme doctors have been "nationalized" in Portugal as well as (already under the pre-war legislation) in Yugoslavia, Hungary and Romania.

The conflict between administration and profession is under way in every scheme. As a laboratory science, perhaps, medicine may operate under a totalitarian regime. As an art, it can flourish only under freedom. The ultimate showdown in medical organization must result either in thoroughly reducing

the operation of the compulsory schemes, or in profoundly curtailing the basic liberty and human rights of all those subjected to them, patients and doctors alike.

BUREAUCRACIES

FIGHT—FOR FREEDOM

It may strike the reader as ironical that the panel bureaucracies are up against the problem of preserving their own freedom. But the fact is that the rule over the panels is also an object of power politics. This is a miniature edition of the eternal conflict between local self-government and centralized administrative power.

The problem does not pose itself in a set-up of free panels, as in Switzerland. Their autonomy is not impaired by federal supervision of a type reminiscent of public utility regulations in this country. However, the question of power-relations arises at once under any sort of compulsory system. Its manifestations vary in accordance with the type of organization outlined in Chapter IV: decentralized panels, as in Germany, Austria, Holland, Belgium, etc. (also under the old French and British schemes); semi-centralization, as in France, and total centralization, in Russia, the Satellite countries and Britain.

From Bismarck to Hitler every German governmental system, including that of Wilhelm II and the Weimar Republic, had made attempts to put the sickness panels under the rule of the federal bureaucracy. Every attempt has failed so far. So did the propaganda of the post-Nazi socialists in Trizonia for "unification."

Brüning clipped the panels' wings by making mandatory significant rules which, before, they were free to elect or to reject. All Hitler accomplished in the organizational direction was to merge (in 1933) all panels for salaried employees into a single, huge unit. German panel officials were and are as adamant and emotional regarding their freedom from regimentation as are the doctors regarding theirs.

The French departmental panels operate in a curious twilight of semi-independence—characteristic of the compromising inconsistency and lack of clear directive inherent in the political structure of the Fourth Republic. Nominally, they are autonomous agencies within the narrow confines of the

law. But the Ministry of Labor has veto power over every move they make and bombards them with circulars, *ordinances* and *arretées* defining and directing their activities in minute detail.² In addition, the Ministry of Finance tries to put its "big toe" in the door of the Social Security under fiscal pretext: to supervise the financial operations. The wire-pulling and intriguing between the two ministries might be worthy of a French comedy. Parliament itself is of two minds on the issue. In 1947, a law was passed permitting the incorporation of new sickness funds having at least 100 members. They became automatically branches of the respective panels. This was a step toward decentralization. But on the other hand, strong forces are at work to throw the whole system into the laps of the Ministry of Finance. Complete "nationalization" would permit economic operation, the argument says. The opponents ask sarcastically: what about the deficit of the nationalized industries?

As it is, the French social security bureaucracy has developed a political power of its own, as shown by the fact that it almost brought about a cabinet crisis in the summer of 1949. The socialist Minister of Labor, Daniel Mayer, authorized arbitrarily an extra month's salary for the employees of the *secrité* in addition to the usual one month's paid vacation. The ensuing political quibble about this "14 months' pay" shook the parliamentary structure of the country.

COLLECTIVIST ADMINISTRATION

Even the Soviets experimented with a semblance of self-government. Under the *Nep*, in 1923, when markets were restored (temporarily), Lenin based his sickness security system on "cells": the plant units and professional organizations. In each of the member "republics" of the U.S.S.R. a central office (*glavsozstrach*) of 5 trade unionists and 8 representatives of diverse commissariats was to do the directing. The crowning link of the hierarchy was the Central Directory of Social Insurance (*tzoustrach*) in the Moscow Commissariat of Labor.³ Stalin abruptly ended this idyll of false pretenses. In 1937, in the midst of the great purge, the whole set-up was abolished, and the central bureaucracy took over hook, line and sinker. The Commissariat (Ministry) of Social Assistance took over the handling of cash benefits while the medical

and hospitalization end fell to the Commissariat of Public Health.

The essential feature of Stalin's organizational regime has been copied by Dictator Salazar in Portugal and by the "democratic" Labor regime of Great Britain. The latter has copied even the dividing of the scheme between two ministries.

THE RATIONALE OF ORGANIZATION

Centralization means the ultimate of large-scale organization—with all the disadvantages but with few, if any, of the advantages of large-scale production. The larger the managerial unit, the more bureaucratic it tends to be, the higher the costs of operation per member, and the less the members receive in actual benefits in kind. German experience provides conclusive material. In low administrative costs as well as in high medical benefits disbursed, both per capita, plant panels (*betriebskassen*) make the most favorable show, with the semi-voluntary "substitute" panels (*ersatzkassen*) close seconds. The huge metropolitan units (*orts-krankenkassen*) rank on the opposite end of the scale. This is as would be expected.

The German panels themselves claim that the optimum size is reached with 50,000 to 60,000 members as against the hundreds of thousands in the large units. (The Bavarians favor even smaller panels, and so do some Swiss experts.) Small size may mean less "perfect" risk distribution, but that turns out in practice to be more than compensated for by other factors. Better, more personalized service to, and control of, the patients by the officials—and of the officials by the members—are decided advantages of the small unit. Also, much if not all of the administrative work is performed by voluntary forces. Instead of an expensive building the part-time use of available office space may do; employees usually are available for part-time work at little or no extra cost, etc. Also, the checking by members of one another's sicknesses is the most effective and cheapest way to restrain spending. Above all, the smaller the unit the less "imperialistic" are its ambitions. Instead, it tends to drive for economies. Small wonder that the administrative cost coefficient of such units often is close to—zero. They are often subsidized, too, by the plants. In Germany, Switzerland and Finland, supervision or actual management of

the plant panel by the plant has been a factor in achieving comparatively far better records (lower costs and higher benefits) than those of the average panel.⁴

In the minuscule Swiss health co-operatives, with a few hundred members each, the co-operation goes so far that the members mutually nurse each other. Of course, such idylls are scarcely feasible in industrial centers, and certainly not for the millions forced into compulsory "cooperation." Being forced they lack that kind of spirit or develop one of the opposite tendency.

THE MEANING OF "UNIFICATION" Such "trivial" details as costs and efficiency are of small import to the statesmen who drive for centralization and unification of the social security set-ups. They claim that unifying related services and running them in a centralized fashion is the "logical" thing to do. It is logical indeed from the political angle. It provides the political boss with a power to dispense favors that is a most effective vote-getting instrument. It also provides for a uniformity that is dear to the collectivist hearts.⁵

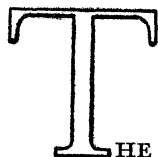
Wherever governmentalized Medical Insurance of a limited scope has been replaced by an all-embracing Medical Security—be it in Russia, England or France—multilateral expansion coincides with the drive toward centralization. The underlying link between the two apparently unrelated tendencies should be obvious. (See Chapter V.)

"Utopias are realizable. Life marches toward the Utopias. And perhaps a new century begins, a century in which the intellectuals and the cultured class will dream of means to escape the Utopias and to return to a non-Utopian society less 'perfect' and freer." Nicolas Berdjaev.

C H A P T E R

F I F T E E N

Some Social Aspects of Medical Socialism



HE 18TH proudly called itself the Century of Reason. The 19th boasted of being the Century of Progress. In the same fashion, the 20th deserves one of two titles: the Century of Marxian Totalitarianism or of Bismarckian Social Security. That the two movements, for governmentalizing the security of the individual and toward unrestrained absolutism, coincide is far from accidental. Both have the same deep psychological root: the longing in the heart of the masses, on which the politician can capitalize, for protection against the hazards of life, cost what the protection may. And both imply vast controls by the State to replace the responsibility of the individual.¹ Both belong in the same chapter of the history book: The Welfare (Police) State.

Short of having reached total power, the Welfare State, like any other, has to win the mass loyalty on which Power depends. Spending one way and taxing the other is the age-old formula. Both have to be supported by arguments.

HUMANITARIANISM AND PATERNALISM Until after the turn of the century, the appeal to humanitarianism provided the Number One argument for governmentalized medicine. Poor people cannot afford to take care of their own health. To leave them to charity, public or private—and both were highly developed long before Bismarck—would be “humiliating.” Why, the poor may be so proud that they might not take the alms and would rather suffer or even die, so the argument implied. Then, there are the semi-poor who

could get along normally, but who might be wrecked by major sickness in the family.

After World War I, more rationalization was needed to justify the horizontal expansion of the schemes to ever higher income brackets. It easily was found in the Bismarckian armory of ideas: people must be insured against sickness in a compulsory fashion because they do not take care of themselves. They do not know how to use their money rationally; the government has to step in and teach them to make sound use of their incomes. The paternalistic image supplements the humanitarian vistas. The implication is that people "lack the insight and the moral strength to provide spontaneously for their own future. But then it is not easy to silence the voices of those who ask whether it is not paradoxical to entrust the nation's welfare to the decisions of voters whom the law itself considers incapable of managing their own affairs; whether it is not absurd to make those people supreme in the conduct of government who are manifestly in need of a guardian to prevent them from spending their own income foolishly. Is it reasonable to assign to wards the right to elect their guardians?"² Also, substituting by authority for the private propensity to save tends to undermine the saving habit which it is supposed to inculcate and to supplement.

Note in passing that the most effective argument for compulsory medicine still is: to provide for people in the low income brackets who cannot provide for themselves. But in practice, and from the outset, the schemes always include a majority of members who could very well take care of themselves. And almost always they leave out a minority, especially the lowest income group, that still has to fall back on poor relief or private charity.

AUTHORITARIANS TURNING RED

World War II has opened a new ideological era. The question is not only of being humanitarian or of teaching people how to spend properly. The question is to provide security for all, and to do so in such a fashion as to equalize the hazards of life between rich and poor, between high-salaried and low-paid, between skilled and unskilled, etc. Equalitarian security is the new goal—the professed goal, anyway.

He who wishes to understand the trends of Europe in the face of the soul-searching effects of World War II must visualize this underlying equalitarian trend. It permeates politics and economics. It is expressed in communist and socialist strength. Equalitarian ideas often blend even with those of parties and movements of a conservative character, to say nothing of those of "fascist" leanings.

PROFESSIONS LOSING STATUS

Equalitarianism is a psychological power of first magnitude that creates a new outlook on life. In Europe, even on this side of the Iron Curtain, it has become almost a part of many people's mental make-up. One of its most spectacular, and from the cultural point of view most significant, manifestations is the pressure to deflate the white-collar middle class and upper-middle class type of society, with its conventional values, its comparative leisure, and its cultural interests. In Britain, in particular, the outspoken sentiment of the masses and the political and administrative weapons in the hands of their representatives are being used to depreciate the position of the professions. Why should any one be better off than a mechanic or lead a life different from his? What that means, why the professional is in need of higher income and more leisure than the artisan, has been succinctly formulated by an English economist:³

"High-grade intellectual work . . . demands a measure of freedom from incessant preoccupation with penny-saving; the half-hour in the rain at the bus-stop, the long wait to borrow the book which one cannot afford to buy, the odd jobs and make-do-and-mend which nibble away time and energy. These things are not necessarily more unpleasant to the professional than to the artisan . . . but they affect his work as they do not affect the artisan's." "It demands, more positively, opportunity; the relaxation in which, deep in the apparently idle mind, ideas meet and cross-fertilize and mature; the stimulus of informal, as well as professional meetings with colleagues and . . . others concerned with a widely different expertise, at home and abroad; the leisure and means with which to balance the claims of specialty with a saving leaven of civilization. All these are expensive."

The medical profession is perhaps most sensitive among all groups of the "intelligentsia" to the effects of this leveling process. In the medical field, study is longer and more expensive, the earning life period shorter, and the investment in technical installations more costly than in any other "academic" activity. Indeed, its contribution to the civilization and progress of humanity rests on a material foundation. To deny the latter is tantamount to stultifying the former. Such a policy may fit into the Garrison State of the Soviets, in which civilization is identical with military preparedness, and progress with regimentation.

INTRA-PROFESSIONAL EQUALITARIANISM

"You know, Lord Horder, as I do, that one doctor is as good as another doctor," said Aneurin Bevan to the spokesman of the British profession. The tendency of authoritarian medicine to level the differences within the profession may be even more significant, perhaps, than the tendency to level the profession as a whole. The second pressure could be corrected by raising the doctors' honoraria—if that were financially possible and politically expedient. But the first is inherent in the very nature of the system. How should the bureaucracy distinguish between one surgeon and another in terms of respective ability? It has to pay both on the basis of well-defined, uniform standards, lest purely arbitrary judgments and corruption should prevail.

The effect on medical practice would be similar to that on a business which had ceased to distinguish between the shipping clerk and the executive vice-president, except in terms of seniority and stop-watch records. Continental panel systems mitigate the devastating ill effects by leaving a substantial sphere of the medical business in freedom. Doctors fortunate enough to retain or to develop a private practice can afford to devote part of their time to the "mechanized" panel practice, while still having sufficient leisure left to develop their art. Where medical security is newly introduced, the profession lives for years on its accumulated capital, so to speak, of past experience and accomplishment. What will happen when private practice fades out, together with the old generation of doctors who grew up in it? So will the beneficial results of private practice on the medical art itself.

The new generation of doctors whose future lies in the compulsory system does not even need the training the old used to acquire. Characteristically, from England comes the suggestion that, in view of the urgent demand for more doctors to relieve the shortage caused by the onrush of non-paying patients, the rank and file of young doctors should be permitted to pass with a training less comprehensive than required at present. According to Dr. J. Plesch, London, a four-year vocational course would do, while future consultants, specialists, and scientists should be the only ones to receive a full-fledged academic and clinical training. *Lancet*, the pro-Bevan (!) British medical journal, commented caustically (April 2, 1949): "Retrograde as this proposal may seem, it is none the less in line with the present tendency of the over-burdened general practitioner to disuse his medical skills and practice medicine on a level little above that of a competent orderly. If we are going to be content with conditions under which real medicine is to be practiced almost exclusively at or from hospitals, why not frankly acknowledge the fact and accept Dr. Plesch's proposal to train our students accordingly?" A second-class training for scheme practitioners should be in accordance with the second-class medical service they tend to supply in most scheme frameworks.

SOCIALIST PURPOSE OF "SECURITY"

The socialistic implications of compulsory medicine, especially in the health security systems of France and Britain, to say nothing of Soviet Russia, have far greater significance than the leveling trend that affects the doctors.

The idea underlying those security systems has been clearly formulated by their leading French representative. According to Monsieur Laroque, "The French social security plan was aimed in essence at no other target than to introduce a little more justice into the distribution of the national income." In other words, and this holds for the British approach as well, not health care *per se* is the prime objective. "Security of the power to work" is incidental only, or so it appears, to the goal of correcting inequalities and injustices in the capitalistic pattern of income distribution. Health care turns out to be one of the pipelines through which the re-canalization of wealth is to be accomplished. It is, to repeat, "distribution, by author-

ity, of part of the national income."⁴ And the master mind whose industry and political efficacy were responsible for putting over the new scheme in France does not hesitate to draw the logical conclusion: a high wage country like the United States needs no compulsory medicine, as does a low wage country like France.

Assuming that the income pattern needs correction: do health schemes help or at least do they contribute to that goal? It takes economic illiteracy to overlook the fact that their cost, if shifted onto business, are most likely to be added to the price of the product which those people buy whose income is supposed to be hiked. *As a class*, the beneficiaries receive at best with the left hand what they lose with the right. Inasmuch as they carry the cost themselves, as they do to an appreciable extent even in France, it obviously comes out of their own pockets.

Even nominal wages tend to be directly affected. It is widely understood that the benefits of social security in general, and of health security in particular, are substitutes for higher wages. A redistribution still does take place, indeed, but not so much between labor and capital as rather among the "beneficiaries" themselves. The young, the healthy, the productive workers have to contribute but may get little or nothing out of the sickness schemes. The sick, the hypochondriac, the unproductive may get much more than they put in themselves or what their share would be in terms of marketwise remuneration for services rendered. Thus, the national income pattern is being reshuffled in the direction of reducing the incentive for productivity. Together with a system of subsidies per child, a system which is part and parcel of social security in Russia as well as in Britain and France, the negative incentive already has reached such proportions that in France, at any rate, special measures had to be taken to stem the inclination of family heads to "retire" on steady family allowances (plus occasional sickness benefits).

Such and similar disincentives account in part for a daily absenteeism among British coal miners which lingers at this writing in the neighborhood of 14 per cent of the manpower, this in spite of all official "pep-talks" to boost the working morale. The effect on production costs is enhanced by the fact

that the most productive workers—the healthiest—consider their contributions to the sickness scheme as an unjustified head-tax. They try to shift it by clamoring for higher wages.

THE SECURITY CART BEFORE THE ECONOMIC HORSE In Europe, medical benefits are the origin and core of all social security. Therefore, the economic, fiscal and financial implications of the one scarcely can be discussed lest the discussion encompass the whole field. The effects of health “security” on the level and structure of wages, on labor mobility (or immobility) and productivity, on production costs and commodity prices, on the saving propensity of the public and its economic “morale” in general—would have to be analyzed in conjunction with old age pensions, family allowances, unemployment insurance, etc. Nor should such “direct” social subsidies as for education and housing be left out of the picture. For all of them it is logical, as expressed by the clear-sighted Canadian economist, Gilbert Jackson, “that a point must at some stage be reached when (for example) the marginal tooth extraction must be balanced off and weighed against the marginal ticket to the rugby game.” In other words, the national income has to pay for everything the nation consumes—unless it lives on its capital or on charity from abroad.

Society is free to turn charity into what is considered the right to minimum welfare for every individual—to “put a floor under poverty.” But it has to balance the welfare results with the consequences in terms of output. And it has to remember that the volume of output is not merely a matter of technology. It depends on “psychology,” on the inter-play of incentives and disincentives, and the resultant readiness or lack of it to carry risks and responsibilities, which in ultimate resort determine the direction and the measure of the productive effort.

All of which may be boiled down to the preference, again quoting Dr. Jackson, between the two very simple philosophies: between the conviction that Every Tub Must Stand on Its Own Bottom and the other belief that Every Tub Needs to be Propped Up.⁵

From the point of view of a non-communist society, social security stands or falls on the assumption that it contributes

to economic stability. Leaving aside the broad aspects of this question, this much is certified by all experience: medical security does not fulfill that goal, whatever else it may accomplish. The medical as well as all other branches of social security can be only a minor factor in the quest for economic stability. As a matter of fact, their utility for that purpose "is dubious unless economic stability is attained."⁶

More is "dubious" than that. Actually, compulsory medicine creates ever-new maladjustments, psychological unrests, political conflicts and social disequilibria. It engenders instability rather than contributes to stabilizing of the economic system. There is no sign anywhere, and no serious student has put forth the claim, that the availability of "free" health care, be it on an Insurance scheme or on a Security plan, has stimulated incentives, mitigated industrial strife, reduced absenteeism, forestalled radicalism, strengthened the respect for the law or made labor disclaim higher than "economic" wages.

COMPULSORY MEDICINE So much has been written about
vs. SOCIAL SECURITY social security in general that it
 would fill a major library. But
 very little has been said about the specific nature and implications of compulsory medicine. Authoritarian medicine is the only branch of the security system the major function of which is to provide gratuities in kind. We have discussed the virtually insoluble problems created by such a design. As no other "security" does, this kind necessitates direct, physical controls which threaten to interfere with basic rights and freedoms. It is a difference such as exists between the government's taking over and running a nation's industry and its protection of such industry by tariffs—the difference between socialism and subsidy.

Of all branches of that great field of humanitarianism called social insurance, the medical is the least predictable in costs and in consequences. As no other, it tends to foster the very thing against which it is supposed to provide insurance. Ironically, in a world that spends more and more to combat physiological diseases, more and more psychological incentives for illness are being fostered.

Another unique feature of compulsory sickness care is that it pretends and tends to offer *full* security of its kind. The idea underlying all other "Security" is to give partial aid only, to furnish a minimum necessary (allegedly) for existence. But in the case of medical benefits in kind, the minimum *must* be sufficient to restore health, which is the complete service, not just the minimum. This is what constitutes the crucial problem of every compulsory scheme.

TOO LITTLE OR TOO MUCH? Scant attention is being paid to the fact that governmentalized medicine performs in one of two ways: it provides either too little or too much. It does not fulfill its function of caring for the sick if the care is restricted by bureaucratism and by high costs (contributions and deductibles) to the beneficiary. In that case, "too little" is given from the point of view of the needy who again might have to fall back on charity.

"Too much" is the real danger. Artificial cheapening of the medical services invites an excessive consumer demand which the available means—doctors, nurses, hospitals, etc.—can not satisfy. That, in turn, not only tends to reduce the quality of sickness care to the point where it ceases to be meaningful, but also creates a disequilibrium in the distribution of national resources. The consequences are manifold; they add up to a significant unbalancing factor in the economic system. Free medicine in Britain, as an example, has caused such a rush of adults for dental care that the number of dentists available for the school dental program has fallen from 3,000 to 700.^{6a} Too much of curative medicine results in too little preventive medicine.

HISTORICAL NECESSITY? When reasoning ends, "historical necessity" serves as a convincing argument. Ever since Hegel and Marx, the alleged logic of history, construed to fit the constructor's purpose, is the successful technique of political and economic propaganda. It works remarkably well. It does so in the hands of governmentalized medicine advocates who use it to provide a pseudo-philosophical background.

The idea is that compulsory health security, whether we like it or not, is a necessity in industrial society and as such cannot be escaped. Look at the facts, they say: it spreads all over the world in the wake of industrial development. That, of course, would not prove *per se* either its necessity or its rationality. But the facts do not corroborate the thesis at all. Actually, Bismarck's Germany of the early 1880's was only at the threshold of industrialization. England, on the other hand, the leading manufacturing country of the epoch, reluctantly followed in the path of governmentalized health care a generation later, more than twenty years after the overwhelmingly agrarian Austro-Hungarian Monarchy adopted a compulsory scheme. Portugal had a nationalized system long before France; backward and rural Romania preceded by some 30 years progressive Belgium teeming with factories; primitive Czarist Russia anteceded an old capitalistic country like Holland. And when Lenin introduced the most comprehensive and "progressive" health care plan, Soviet Russia probably was the most retrograde of any country in Europe in terms of per capita motor power. Presently, of all the great industrial nations, only two do not have any sort of governmentalized sickness plan, and they happen to be the world's leaders in industrial mechanization: the United States of America and the Dominion of Canada. In all of this, just where is that famous historical necessity?

If a modern country such as Sweden with its very high degree of industrial skill is a late-comer among the governmentalizers of medicine, if Switzerland refuses to go all of the way, and if Finland stands aloof, well, the reason is, we are being told, that to a large extent these nations still are dominated by farming communities. And there is less need for health care in the salubrious atmosphere of rural life, so they say, than in the congestion of metropolitan centers. But the facts are that overwhelmingly agrarian countries like Australia and New Zealand are among the leaders in medical governmentalization. In Germany, on the other hand, the same advocates of authoritarianism want to extend their system into the farming communities, and point out rightly the higher rural mortality rate. Apparently, if one believes in a system, self-contradictory arguments can be used in its favor without intellectual embarrassment.

**BALANCE SHEET OF
MEDICAL GOV-
ERNMENTALIZATION**

Reduced to a rational denominator, the "historical argument" boils down to something worth serious contemplation. It is this. Disregarding the humanitarian aspects of the question, labor is the most valuable "natural resource" we possess. It has to be protected in every way against "depreciation and obsolescence." From a purely economic point of view—if it is permissible in this emotional age to think for the moment in such "inhuman" terms—the implication is that the cost of governmentalized medicine is money well spent on maintaining labor's productivity, avoiding longer than necessary incapacitation and early invalidity. Eliminating the psychosomatic effects which otherwise reduce the output of the worker, whose mind is burdened with the fear of illness, in itself would be a worth-while objective.

Who would quarrel with the obviously sound base of this reasoning? It is as economically sound as is ethically axiomatic the humanitarian argument that the helplessly sick must be cared for. As a matter of fact, if the "statesmen" have been able to make capital of medical care, it is because they could and can appeal to incontestable social reasons and sentiments. But that is not the problem. The problem is whether the sound and desirable objectives on which we all agree could or could not be pursued but by the one and only way of salvation, as the opportunistic politician claims: by recourse to governmentalized compulsion and to massive subsidies.

It definitely is desirable that the public should be protected by compelling every car owner to buy a liability policy. But does it follow by any logic that therefore the casualty insurance business must be nationalized? By the same token, life insurance companies would have to be nationalized, too, and the amount of the individual's coverage fixed by law. Who would object to providing the indigent with the necessary food? But does it follow that the distribution of food for every one or for all wage earners should be put into the government's hands?

The simple logic of the matter was expounded seventy years ago by true Liberals—like Lujó Brentano of Germany—who did not oppose Bismarck on dogmatic laissez-faire grounds.⁷ They actually proposed compulsion, but with the free choice of

the workers to build their own panel organizations or to join any of their liking. This, in essence, is the Swiss system, or it comes nearest to it, although much improvement on it could be made. And the indigent still could be cared for by special charity arrangements—which need not be “humiliating”—subsidized by local rather than national governments. Such a system would fulfill the desirable objectives, economic and humanitarian, and would avoid the political, bureaucratic, financial, and ethical fallacies which corrupt the governmentized systems to the serious detriment of national life.

Even so, the fundamental fact remains that no country can provide more in sickness care than its economic production permits. Ultimately, the status of health care depends on the level of wealth, not on schemes of one kind or another.

When the state enters a field of private activity, that field turns into a battleground of organized pressure groups, political and professional, pro and con, often disguised under ideological movements. The one group that is not suited for organization, but the one in whose name all others claim to speak, rarely receives adequate representation in the literature and even less so in the political arena. The *Unknown Patients*, lost in the scramble of selfish powers, are the ones whose welfare should be the sole guiding principle of public policy in the medical field.

* * *

Readers of this book may ask for one free copy of “The Right Way to Provide Security Against Illness and Old Age,” by Willford I. King. Write to:

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References by Chapters

CHAPTER ONE:

¹ Jacob Burckhardt, *The Age of Constantine the Great*, 1852; English translation, New York, 1949, p. 62.

² Lujo Brentano, *Der Arbeiter-Versicherungszwang*, Berlin, 1881, pp. 94 ff. "Compulsory sickness insurance," wrote Brentano almost 60 years ago, "is not to be considered as an isolated economic measure. It is part and parcel of the great economic program which is built in all its elements on the same basic idea. Not only are the chief advocates of the railroad nationalization, of the governmental monopolization of all insurance, the nationalization of vital industries, of the governmental administration of the banks, and of the transformation of agricultural credit institutes into State organs, the same persons who propose to force the workers into obligatory panels—the inherent unity of all these measures and projects calls for no proof. Once we are that far, the situation then will be simply that the economic life of each individual will be woven in the most intimate fashion into the activities of the State and dependent on the measure of its administration."

³ Quoted in Manya Gordon's *Workers Before and After Lenin* (E. P. Dutton and Co., 1941) p. 290.

CHAPTER TWO:

¹ M. J. Bonn, *Wandering Scholar*, New York, 1949, Chapters II and III.

² See, for a typical example, article "Health Insurance" by J. L. Cohen in the *Encyclopedia of Social Sciences*, Vol. VII, 1932, p. 294: "It was Bismarck's great achievement that he took advantage of the expanding mutual aid movement, led the humanitarian sentiment of the 1870's and 1880's and made acceptable the thesis that compulsion was inevitable." "Bismarck made it clear that the thorough-going paternalism removed the legitimate causes of socialism." The learned author not only makes a humanitarian out of a Bismarck, but also implies that there is no more socialism left but of an illegitimate sort.

³ W. A. Sollohub, "Social Security in France," *Harvard Business Review*, Spring 1937, pp. 283 ff.

CHAPTER THREE:

¹ Bismarck's Christianity is well illustrated by his statement (quoted by Eyck, *Bismarck*, Vol. III, p. 371): "He who has a pension for his old age is much more satisfied, and much easier handled than he who has no such prospect; . . . he will take much more on the chin, will show much more attachment to his job than the other; why, he expects a pension."

² G. de Lagarde, *Sécurité Sociale, Législations Nationales Comparées*, Paris, 1945 (unpublished manuscript).

³ Sir William Beveridge, *Social Insurance and Allied Services*, The Macmillan Co., New York, 1942.

CHAPTER FOUR:

¹ An incomplete (and unsatisfactory) bibliography of literature on free panels is to be found in the official *Public Health Reports* (Washington, D. C.) of May 23, 1947: "Voluntary Health Insurance in Western Europe," by St. J. Perrott and J. W. Mountin. See also the publication of the International Labor Office: *L'Assurance Maladie Libre*, Genève, 1927. About the evolution of Swiss panels: Kinkel, *Gegenseitige Hilfsgesellschaften der Schweiz*, Bern 1903. Reports of individual free panels or of their federations are the main current source of information about them. Consult: Barbara Armstrong, *The Health Insurance Doctor*,

Princeton U. Press, 1939, pp. 101-164, on Denmark (detailed but superficial); A. Gourdin, *Les Sociétés de Secours Mutuel*, Paris, 1920 (on France); L. Brentano, *Zur Geschichte der Englischen Gewerkvereine*, Leipzig, 1871, for the origins of English panels.

² The American counterpart, but without the community type of organization, sponsored by doctors rather than by the patients themselves, is the prepaid health scheme. Cf. the (unevitable) compilation of Herbert D. Simpson, *Health Protection: A Study of Pre-Payment Medical Service Plans*, Chicago, 1946.

³ Their *Knappschaften* counted 190,000 members in 1869, and 410,000 a decade later.

⁴ The best and most up-to-date international survey of compulsory sickness security legislations is the *Analyse Comparée de la Législation Etrangère sur l'Assurance-Maladie*, as of March 20, 1947 (printed as manuscript) of the Swiss Federal Office of Social Insurance. The comparable publications of the International Labor Office (Geneva): *Die Obligatorische Kranken-Versicherung* (1927) and *Die Sozial-Versicherung im Jahre 1929* (1930), are purely legalistic and antiquated. Currently, the International Labor Office publishes in English the text of sickness insurance laws of a number of countries.

CHAPTER FIVE:

¹ For abundant samples of mercantilist (16th to 18th centuries) policies along the lines of what is called today Full Employment and Social Security, see C. W. Cole, *Colbert* Vol. II. New York, 1939, pp. 472 ff.; C. W. Cole, *French Mercantilism 1683-1700* New York, 1943, pp. 212 ff.; L. E. Heckscher, *Mercantilism*, London, 1935; E. Lipson, *The Economic History of England*, Vols. II and III, London, 1934, and article "Merkantilismus" in *Handwörterbuch der Staatswissenschaften*, Vol. VI, 4th ed., Jena, 1925 (with bibliography).

² Professor Antonelli in the *Revue d'Economie Politique*, 1947.

³ Pierre Drouin, in *Le Monde* of February 8, 1949, part of a series of excellent articles on the French scheme. The other articles appeared February 3, 4, 6-7 and 10, 1949.

CHAPTER SIX:

¹ "... One knows that patients are going for things like bottles of cough mixture and aspirins and so on which they did not go for before," was the explanation given by the accountant-general of the Ministry of Health before the *Select Committee on Estimates* (May, 1949, p. 59).

² French official statistics, incidentally, are very meager. Reliable current data are obtainable from the federation of French panels, known as F.N.O.S.S. (Federation Nationale des Organismes de la Sécurité Sociale). They are published and incisively analyzed in the privately circulated Letters of the *Comité Central des Institutions Sociales*, under the direction of G. de Lagarde. The official exchange value of the French franc has depreciated from about 2½ cents before the last War to less than one-third of one cent by the end of September 1949. Currently, the deficit of the French sickness security is covered by funds taken from the old age security.

CHAPTER SEVEN:

¹ Current official publications, the latest available, on the Swiss system's legislative set-up and the statistics of its operation, all by the Federal Office of Social Insurance (Bern): *Die Obligatorische Krankenversicherung in der Schweiz*, as of January 1, 1949; *Statistik über die vom Bunde Anerkannten Krankenkassen und Tuberkuloseversicherungsträger*, 1947; *Caisses-Maladie Suisses et Caisses d'Assurance Contre la Tuberculose*, 1938-1943 (1946).

² German statistical data compiled from the following official sources: W. Dobernack, "Entwicklung und Stand der Deutschen Sozial-Versicherung," in the *Jahrbuch der Kranken-Versicherung*, 1929; *Statistisches Jahrbuch für das Deutsche Reich*, annual; Unger-Wiegelow, *Tabellenwerk der Deutschen Kranken-Versicherung*, 2. ed., 1932; *Die Kranken-Versicherung 1937* (in the series "Statistik des Deutschen Reiches," vol. 529) Berlin, 1939; *Die Deutsche Sozialversicherung*, 1938, published by Germany's Federal Insurance Agency, Berlin (1939).

³ Ministère du Travail et de la Prévoyance Sociale (Bruxelles): *Rapport Général sur l'Année Sociale 1947*, 2 vols.; do., "Les Barèmes de l'Assurance Obligatoire," in *Bulletin d'Information du F. N. A. M. I.*, November 1, 1948.

CHAPTER EIGHT:

¹ For the early development of medical relations in the compulsory schemes, the best treatises are T. Plant, *Der Gewerkschaftskampf der Deutschen Aerzte*, Karlsruhe, 1913; H. Korkisch, *Die Arztfrage in der Sozialversicherung* (a symposium), Prag, 1926; and the dissertation of G. Augustin, *Die Arztfrage in der . . . Sozialen Kranken-Versicherung*, Berlin, 1931, with extensive international bibliography; Finkenrath, *Die Kassenarztfrage im In-und Auslande*, Berlin, 1931. Best up-to-date summary of the doctors' and pharmacies' legal status in the German scheme: Gustav W. Heinemann, *Kassenarztrecht*, Berlin, 1942. The complex regulations of entering panel practice in Germany are fully reprinted and interpreted in Fr. Thieding's *Die Zulassung zur Kassenärztlichen Tätigkeit*, Hamburg, 1948.

² According to one expert, medical incomes were declining since—the 17th century; Kurt Finkenrath, in *Gross-Berliner Aerzteblatt* of September 18, 1926.

³ Based on the *Report of the Interdepartmental Committee on the Remuneration of Consultants and Specialists* (Spens Committee Report) of the Ministry of Health, 1948 (Cmd. 7420).

⁴ Ministry of Health, *Report of the Inter-Departmental (Spens) Committee on the Remuneration of General Dental Practitioners*, 1948 (Cmd. 7402).

⁵ G. W. Morey, "The Position of the Specialist To-Day," in *Fellowship for Freedom in Medicine*, Bulletin No. 6, October, 1949 (London).

CHAPTER NINE:

¹ Antonelli, *op. cit.*

² For the treatment Lloyd George meted out to the British Medical Association—that willingly offered its co-operation—the learned study of the late Professor Herman Levy, *National Health Insurance* (Cambridge, 1944) produces rich documentation. It is the best analysis of the Lloyd George panel system.

³ But by appealing to the Supreme Court of Australia, the doctors of that Dominion succeeded in stopping the government's attempt to force them into issuing special prescriptions for "free" medicine.

CHAPTER TEN:

¹ The *Nomenclature Générale des Actes Professionnelles*, published by the F.N. O.S.S. (2. ed., Paris, 1948) gives the "nomenclature," in capital letters and numbers, of all medical "acts." The same designation may serve for any number of them: K x 25 may mean a throat, ear or eye operation—at the identical fee to the respective surgeons. This technique of remuneration is supposed to guarantee professional secrecy.

CHAPTER ELEVEN:

¹ "Liberal" labor economists take the same attitude of ignoring or pooh-poohing the corruption charges. Typical was the otherwise outstanding German book on labor problems, *Die Arbeiterfrage*, 2 vols., Berlin, 1926, of the very dignified and

learned Professor Heinrich Herkner (Berlin). When it came to the crucial questions of compulsory medicine, he lost academic dignity and scientific temper. The problems simply are ignored by R. M. Woodbury, *Social Insurance, an Economic Analysis*, New York, 1915; and by most other "economic" writers on the subject. See also Frieda Wunderlich, *Der Kampf um die Sozialversicherung*, Berlin, 1930.

² Similar "statistics" are forthcoming from satellite countries. The Polish *Workers' Tribune* (Warsaw) reported lately that in one Silesian coal mine 19.5 per cent of the staff had not worked in July, 1949. "At the Siemianowice mine the July absenteeism rate was 17 per cent, of which justified absenteeism amounted to only 1.5 per cent. 'The rest,' a party secretary charged, 'are loafers who manage to bring a doctor's certificate.'"

³ Partly, this is the doctors' own undoing due to their tendency to emotionalize the issue. The voluminous German professional literature is, in particular, loaded with exaggerations about corruption in the sickness scheme. But the following books, among others, contain much material that the writer could ascertain with reasonable accuracy: Erwin Lieck, *Die Schäden der Sozialen Versicherungen . . .*, München, 1927; W. Lincke, *Krankenstand und Arbeitwille*, Berlin, 1930; W. Stappert, *Krankenschein Gefällig?*, München, 1928; Stefan Feigenbaum, *Die Tendenz zur Sozialisierung der Ärztlichen Hilfe in Deutschland und Oesterreich*, Berlin, 1923; A. Schlossmann, *Die Krise des Arztstandes*, Leipzig, 1930; Fr. Wolff, *Der Kranke und die Krankenversicherung*, München, 1928.

⁴ *Seventh Report* of the Select Committee on Estimates, 1949, p. 28.

⁵ The chief exposé of abuses and "rent-hysteria" in the German workmen's compensation scheme was Professor Ludwig Bernhard. Unfortunately, his biased presentation reduces the value of the rich material in his *Unerwünschte Folgen der Deutschen Sozialpolitik*, Berlin, 1912. A high official of the Swiss obligatory accident insurance system pointed out actual frauds in that scheme, based on co-operation between doctors and patients: Otto Keller, *25 Jahre Suval*, 1946.

CHAPTER TWELVE:

¹ G. Scott Williamson, *Physician Heal Thyself* (Faber and Faber, London, 1944). This scintillating little book deserves widest publicity, notwithstanding some of its dilettante aspects in matters of social, as different from medical, policy.

² Ferdinand Oeter, M.D., "Revolutionary Thoughts on the Reorganization of the Sickness Insurance," in the German magazine *Versicherungs-Wissenschaft und Versicherungspraxis*, No. 7, 1948.

³ The testimony of a top official of the German social insurance administration may be worth quoting: "The physician must give way to the demands for benefits and certificates if he wishes to preserve the good will of his clientele. It is not conscious intention or malice against the panel that drives the physician to act this way; he cannot do otherwise, he must take the patient's side or else he cuts off the branch of the tree on which he sits." A. Grieser, in the official periodical *Die Reichsversicherung*, August, 1930.

⁴ Even some official indication of this is available. See the *Seventh Report* of the Select Committee of Estimates (House of Commons) on the Administration of the National Health Services, May 1949, p. 21.

⁵ The importance of such non-medical elements for the medical history of each case is forcefully stated in the autobiography of an outstanding heart specialist, Professor John Plesch, *Janos, the Story of a Doctor* (A. A. Wyn, Inc., New York, 1949).

⁶ On the family doctor: David Riesman, *Medicine in Modern Society*, Princeton, 1939; and on his epidemiologic significance: Thomas Francis "The Family Doctor," in *The Journal of the American Medical Association*, Oct. 1, 1949.

⁷ Quoted by Dr. L. H. Bauer, *Private Enterprise or Government in Medicine* (Springfield, Ill. 1948) p. 47.

CHAPTER THIRTEEN:

¹ There are some 80 different techniques of deductibles in use to substitute for the price mechanism, to reduce the scheme expenditures, and to "punish" the beneficiary by burdening him with some part of them, including the Brüning method of a charge on the sickness ticket which the patient has to fetch before going to the doctor. See the dissertation of Elsa Schnurrenberger, *Die Ausgabensteigerung . . . in der Schweizerischen sozialen Krankenversicherung*, Bern, 1939. (After this present book went into print, the British government announced the increase of a one shilling, or 14¢, charge on each prescription.)

² A short and enlightening survey of such futile methods of pharmaceutical control is offered in G. de Lagarde's article "Les Assurances Sociales," in the symposium *Législation Sociale Appliquée*, Paris, 1943, p. 121.

³ The process is vividly described by Mrs. J. K. Irvine: "How British National Health Prescriptions are Priced," in *American Druggist*, July 1949.

⁴ "After these cuts," the chairman of one regional hospital board said, "the service will be put back 20 or 30 years. Most of what was gained in the thirties will be lost." (*Daily Telegraph*, London, May 20, 1949.) Note that the "necessity" to refinance the hospitals was a chief argument for their nationalization.

⁵ The official *Rapport General sur . . . l'Assistance publique*, by Monsieur de Fontenay, to the Conseil Municipal of Paris (1947), describes extensively the financial and technical plight of the massively subsidized public hospital system of Paris. An even more vivid picture of mismanagement and corruption is painted by Roland Marchais, "Du côté de l'Assistance publique de Paris," in *Le Monde*, April 20, 21 and 22, 1949. About the deplorable condition of London's "voluntary" hospitals, see the Liberal Party's report, *Health for the People*, London, 1942, pp. 12 ff. They are becoming more deplorable under the new scheme. See also R. M. Cunningham, "Hospitals Under Socialized Medicine" (in England), *The Modern Hospital*, 1949.

⁶ *Le Figaro* (Paris) of May 15, 1949.

⁷ By Professor P. T. Swanish: *The Cost of Dental Care Under Health Insurance*, published by the Chicago Dental Society, 1938.

CHAPTER FOURTEEN:

¹ A summary of elaborate procedures in controlling the British doctor (including "Investigation of Excessive Prescribing", "Investigation of Certification", "Investigation of Record Keeping", "Recovery of Cost of Substance Held Not to Be a Drug", "Power . . . to Consider Complaints", etc.) in *Statutory Instruments*, 1948, No. 507.

² The Federation of French Social Security "organisms" (called F.N.O.S.S.) employs some 80 people for the sole purpose of clarifying and interpreting the texts which the Ministry of Labor shoots at panels. Pierre Drouin in *Le Monde*, February 3, 1949.

³ Cf. A. Abramson: "Social Insurance in Soviet Russia" in *The Journal of Political Economy*, Chicago, 1929; L. P. Borberg: "Ueber die Sozialversicherung in Sowjetrussland," in *Reichsversicherung*, 1928; B. G. Dansky, *Sozialnoe Strachovanie ranshe i sevodnja* (Social Insurance Before and Today), 2. ed., Moscow, 1928.

⁴ Very little literature exists on the "sociological" aspects of sickness insurance, such as the operation of small and large panels. The most exhaustive study of German plant panels is that of Rudolf Schwenger, *Die Deutschen Betriebskrankenkassen*, München und Leipzig, 1934. About Swiss plant panels: Carlos Ochsner, *Die Schweizerischen Betriebskrankenkassen* (dissertation), Uster, 1938. See also Barbara Armstrong, *op. cit.*

⁵ On the political and financial consequences of unification as demanded by the Western German Social Democrats, see the thorough and critical study of Professor Fritz Curschmann, *Jedermann und die Reformpläne zur deutschen Sozial-*

versicherung, Nürnberg-Mimberg, 1947, and J. Eckert, *Zur Neugestaltung der Deutschen Sozialversicherung* (1948). Complete bureaucratic control is the consequence of the sickness scheme unification in Germany's Eastern (Soviet) zone as shown in detail by Professor Hermann Dersch, *Sozialversicherungsrecht in der sowjetischen Besatzungszone Deutschlands*, Berlin, 1949. A similar system has been introduced early in 1948 in Czechoslovakia—one of the first acts of the Gottwald regime. See *Czechoslovak National Insurance*, Prague, 1948, with introduction by Evzen Erban, communist Minister of Social Welfare.

CHAPTER FIFTEEN:

¹ "It should be remembered that the rise of the totalitarian state was coincident with the general reception of the idea of the *service state* and that both have Marxian socialism in their pedigree. Each in its way postulates an omniscient administration by supermen. If experience may be vouched, that means in the end supermen under the direction of an ex-officio superman." Roscoe Pound, "The Professions in the Society of Today," in *New England Journal of Medicine*, September 8, 1949.

² Ludwig von Mises, *Human Action*, Yale U. Press, 1949, p. 613.

³ Honor Croome, "Liberty, Equality and Full Employment," in *Lloyd's Bank Review*, London, July 1949.

⁴ Pierre Laroque, "From Social Insurance to Social Security: Evolution in France," in *International Labor Review*, June 1948, p. 588. Actually, a modernistic school of French economists (e.g., Louis Alvin, *Salaire et Sécurité Sociale*, Paris 1947) speaks of a *salaire d'inactivité*—a wage for not doing anything—as a new constituent of workers' income.

⁵ Gilbert Jackson, "Resurgam: The Gold Standard vs. Modern Substitutes," *The Canadian Banker*, Spring 1949, p. 3.

⁶ Lewis Merian, "Social Security in an Unstable World," *American Economic Review*, May 1947, pp. 335 ff.

^{6a} Dr. Harold Hillenbrand, "Britain Pays Through the Teeth," in *Nation's Business*, December 1949.

⁷ L. Brentano, *Die Arbeiterversicherung gemäss der heutigen Wirtschaftsordnung*, Berlin, 1879.

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