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Health Insurance, the Medical Profession, and the Public Health

Including the Results of a Study of Sickness Expectancy[1]

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The interest manifested by the medical profession and by health officials in the proposals for governmental health insurance in this country is as commendable as it is necessary. Any measure that may effect the quality and extent of medical service or that possesses possibilities in the prevention of disease is, it will be generally conceded, a proper subject of personal and professional concern to the physician, and a matter of vital consequence to public health administration. Health insurance—at least in some of the forms in which it has been suggested—without doubt is such a measure. In fundamental ways it proposes to modify some of the existing conditions of the practice of medicine. In a quite definite manner it promises to involve the social efficiency of all who are engaged in the work of conserving the health of individuals and of communities.

The physician and the health official, furthermore, perform a distinct service if they judge the various plans for health insurance by the criterion which these considerations suggest. It is proper, it is necessary, that certain questions be asked the proponents of any proposed form of governmental health insurance:

What effect will it have upon the professional work of the practicing physician and upon the quality of medical service?

In what ways does it afford the promise of more effective and extensive activities in disease prevention on the part of existing public health agencies?

Will the physician be enabled to do his work more efficiently, or will he have even greater handicaps than he already has?

Will public health administration be helped or hindered?

[1] Read at the annual meeting of the Medical and Chirurgical Faculty of Maryland at Baltimore, Apr. , 1917.

Sickness Insurance

For purposes of clearness it may be well first to state in a few words what health insurance, or, as it was formerly termed, "sickness insurance," means. Sickness insurance is a method by which the economic loss caused by sickness is distributed among a group of persons. The distribution is effected by the payment of periodic premiums on the part of the members of the group. In this way the cost of sickness arising from the stoppage of income, from fees of doctors, nurses, and hospitals, from expenditures for medicines, and the like, does not come as a sudden financial burden to the insured individual. This kind of insurance is now provided in the United States by many commercial companies and by thousands of fraternal orders and benefit associations of a wide variety of types, and is taken advantage of by a large proportion of those who are thrifty enough and financially able to pay the premiums. In the principal European countries sickness insurance of wage earners has been made a governmental function, but with certain fundamental differences from that form of sickness insurance which exists in this country. Among these differences are its extension to all wage earners upon a compulsory basis, the addition of medical and hospital service and certain other benefits to the cash payments to the sick, and the distribution of the cost of insurance not only among the insured, but also among the two other groups—employers and the public—who are considered responsible, in some degree, for the conditions which affect the health of the insured.

Health Insurance

The proposals for governmental "health insurance" in the United States not only adopt the principles just mentioned, but include additional features. Among these are an adequate medical service for the insured, and definite provisions for rendering the health-insurance system an aid to disease prevention. It has been proposed that the preventive force of governmental health insurance should not be limited to the financial relief during sickness, to the medical service afforded, and to the possible economic incentive to reduce sickness, but that it should be greatly increased by linking the health-insurance system to the existing public health agencies. In this sense, "sickness insurance," it is believed, would become a real health measure. It would not be merely a variety of commercial or mutual insurance or another type of public relief but a practicable method of improving and extending the present facilities for the prevention of disease.

From the viewpoint of the physician and of the public health official, the principal points which suggest themselves for the consideration of "health insurance" are as follows:

1. The sickness expectancy, i.e., the amount of sickness for which medical and surgical service must be provided.
2. Methods of providing adequate medical and surgical relief.
3. Methods of adequate prevention of sickness.

1. Sickness Expectancy

Although in the absence of accurate statistics of morbidity in the United States it is impossible to arrive at accurate estimates of the amount of sickness occurring among wage earners, nevertheless considerable information concerning

sickness expectancy may be obtained by a study of the experience of establishment sick benefit funds. Several estimates have been ventured, some of which have been based on extremely scanty material and some on more reliable data from surveys of actual sickness in industrial communities and from records of disability among employees of establishments. The wide difference in these estimates, from 6 to 9 days of sickness a year per wage earner, has served to call attention to the urgent need for accurate statistics.[1]

a) Investigations concerning sickness expenctancy.—In the last two years the results of several "sickness surveys" or censuses have been published and have added materially to the very scanty American morbidity experience previously existing.

By the survey or census method the number of persons found sick on a given day in an enumerated population and recorded, affords the basis for computing the sick rate per 1,000 of the censused population as a whole or in sex, age, and other groups. In 1915–1917, 579,197 persons were censused in various localities by agents of the Metropolitan Life Insurance Co.; two censuses were made of certain districts in New York City by the department of health of that city; a survey was made of Dutchess County, N.Y., by the State Charities Aid Association; and several surveys have been made in a number of textile villages in south Carolina by the United States Public Health Service. Without attempting to present and discuss in detail the variations in rates among persons of different sex, ages, occupations, localities, income, or other conditions, reference may be made to indicate morbidity rates and annual days of sickness per person among populations 15 years of age and over.

In the following table the experience from the above-mentioned sickness censuses is summarized. The results of the Dutchess County survey are not in a form that is comparable with the results of other surveys, and are omitted from the table.

With reference to the rates in Table 1 it should be noted that the rate for Government clerks is probably for a preferred occupation. The rate approximates quite closely that for office employees afforded in the experience of the Leipzig local sickness fund during 1887–1905.[2]

The extremely high rate among the population of South Carolina textile villages, on the other hand, is probably due to a relatively low economic status.[3]

b) The authors' investigation concerning stickness expectancy.—In the investigation here described, data were collected from over 400 sick-benefit associations, covering, in the majority of instances, an experience of three years, have been collected. These data consist of records of disability due to sickness and nonindustrial accidents for which cash benefits have been paid under the various regulations of the associations, and afford this kind of sickness experience among over three-quarters of a million wage earners engaged in many different

[1] The American Association for Labor Legislation in 1911 estimated that the American wage earner loses on an average 8.5 days per year on account of sickness. The Federal Commission on Industrial Relations, in its staff report estimated from such records as were then available that the average loss of time from disabling sickness and nonindustrial accidents was about 9 days per year per wage earner. The Social Insurance Commission of California in 1917 from a study of the records of American Benefit Association that were collected by the Federal Bureau of Labor a number of years previous and of such data as were available from similar records in California, estimated that the average loss of time per year per person was 6.5 days.

[2] See Twenty-fourth Annual Report of the United States Commissioner of Labor, vol. 1, pp. 1281--1341.

[3] For a discussion of the sickness rate among persons of different family income in the population consused see Public Health Reports for Nov. 22, 1917. *Sup. cit.*

Table I Cases of disabling sickness and rate per 1,000 of various populations 15 years of age and over, and indicated average annual number of days of disabling sickness per person

Population censused	Cases of sickness		Indicated number of days of sickness per person per year of—	
	Number	Rate per 1,000	300 days	365 days
16,000	256	16.0	4.8	5.8
376,573	8,636	22.9	6.9	8.4
20,169	552	27.4	8.2	10.0
2,367	114	48.2	14.5	17.6

Source of data

Records of sick leave of Government clerks in Washington, 1914[1]
Sickness surveys in various localities by the Metropolitan Life Insurance Co., 1915-1917[2]
New York City Health Department "illness census" of health district No. 1, 1916[3]
U.S. Public Health Service sickness census of 7 textile villages in South Carolina, 1916[4]

[1]Warren, B. S. Sydenstrucker, Edgar. Statistics of Disability—A compilation of some of the data available in the United States Public Health Reports, Apr. 21, 1916.

[2]See appendix B: Combined Sickness Experience of the Company's Surveys, 1915 to 1917, of the Metropolitan Life Insurance Co.'s publication. Sickness Survey of Principal Cities in Pennsylvania, and West Virginia, by Lee K. Frankel, Ph.D., third vice president, and Louis I. Dublin, Ph.D., statistician. The "combined sickness experience" referred to included the results of sickness surveys made in localities in Pennsylvania, West Virginia, and North Carolina, Kansas City (Mo.), Boston, Rochester, Trenton, and Chelsea (New York City).

[3]Wynne, Shirley Wilmott Second Illness Census in the Experimental Health District Monthly Bulletin of the Department of Health of the city of New York, November, 1916.

[4]Sydenstricker, Edgar, Wheeler, G. A., and Goldberger, Joseph, Disbaling Sickness Among the Population of Seven Cotton Mill Villages of South Carolina, in Relation to Income. Public Health Reports, Nov. 22, 1918.

industries and occupations. The collection and tabulation of the information have not been completed, but it is possible, for purposes of illustration, to present some preliminary figures for groups of wage earners who are members of one or two types of sick-benefit funds. It should be kept in mind that any conclusions suggested by these statistics ought to be regarded as tentative for the reason that more complete data covering a larger sickness experience are yet to be compiled.

More trustworthy information, it is believed, will be afforded when certain inquiries now under way are completed and when the systematic reporting of morbidity among wage earners is begun. An effort is now being made by the United States Public Health Service to collect such statistics of disability as are at present available in the experience among employees of industrial establishments.*

For presentation here the disability records of those sick-benefit associations which pay no benefits for the first three days of sickness, or for illnesses of less than four days' duration, have been selected because a similar provision has been included in the health insurance bills that have been introduced in various State legislatures. Data for 23 of these associations have so far been collected. They include approximately 150,000 members,[1] for the great majority of whom

*See: Industrial Establishment Disability Records as a Source of Morbidity Statistics. p. 186. Ed.]

[1]It may be noted that the members of the 23 associations were nearly all males, the females constituting a negligible proportion, and, so far as could be ascertained, were adults of the usual wage-earning age period. They were employed in a variety of industrial plants and in various occupations; their sickness experience, however, is not large enough to permit of accurate indications of the influence of occupation. Since industrial accidents are not included, and since the members are fairly well distributed among different occupations in the groups presented in the table which follows, the occupational factor may be disregarded for the purposes of this illustration. To a considerable extent the members are a selected group; some of the associations require applicants for membership

a three years' (1914, 1915, and 1916) experience is available, which makes possible a consideration of 463,714 years of exposure of membership.[1] The regulations of the associations, however, are not uniform with respect to the maximum length of the period for which benefits can be paid; for this reason the statistics are presented according to groups of associations having the same or nearly the same maximum benefit period. The statistics follow:

Table II Sickness and nonindustrial accident statistics of 22 establishment sick-benefit funds having a three days' waiting period, for 1914, 1915, and 1916: Classified according to length of benefit period

Maximum period for which benefits can be paid (weeks)	Number of funds	Years of exposure of membership[1]	CASES OF SICKNESS: Total number	CASES OF SICKNESS: Rate per per 1,000 per year	DAYS OF SICKNESS: Total number	DAYS OF SICKNESS: Per case	DAYS OF SICKNESS: Per member per year
16 and under	13	18,335	6,130	334	81,382	13.3	4.4
23 to 26	4	4,688	1,840	392	28,100	15.3	6.0
52 and over	6	440,691	213,312	484	3,898,576	18.3	8.8
Total	23	463,714	221,282	477	4,008,058	18.1	8.6

[1]By "years of exposure of membership" is meant the number of members for whom a 1 year's sickness and nonindustrial accident record was obtained. The approximate number of persons who were members of the funds can be obtained by dividing the years of exposure of members by 3.

It will be noted that, as may be expected, the waiting period being the same for all associations considered, the average days of compensated sickness per case tends to increase according to the maximum length of the benefit period, and determines the trend of the average days of sickness per member. The importance of the length of the benefit period in determining the amount of sickness for which benefits are to be paid under a system of health insurance is thus suggested. The sickness experience covered in the foregoing statistics is too small to afford definite indications of the experience under any given benefit period except, probably, for those associations having benefit periods of 52 weeks or more. For those six associations, with 440,691 years of exposure, we have a rate of 8.8 days of sickness per year per member.

The sickness expectancy for associations having a maximum benefit period of 26 weeks is, however, of especial interest because some of the health insurance bills introduced in State legislatures contain a similar provision. Unfortunately, until the data obtained are more completely tabulated and adjustments made for varying waiting and benefit periods, our statistics are rather meager. The rate of 6 days of sickness per member per year and of 392 cases of sickness per 1,000 members per year for the group of associations having benefit periods of 23 to 26 weeks appears to be conservatively low,[2] especially when it is compared

to pass a physical examination and to be under 45 years of age, and nearly all had provisions which operated to exclude casual laborers from their membership. The possible influence of administrative methods and practices upon the sick rate is more difficult to determine; the possible effect of the amount of the cash benefit, however, may be disregarded for purposes of approximation, since, for the most part, the cash benefits provided ranged between one-third and one-half of the wages.

[1] Years of exposure of membership were ascertained from the records of the associations by securing the average memberships for each month in each year and computing the average yearly membership by dividing the total of the monthly membership by 12.

[2] If the average annual case rate of 477 per 1,000 for the entire group of 23 associations included in the foregoing table be used as possibly a more accurate base, the days of sickness per member per year for the 4 associations with a benefit period of 23 to 26 weeks would be 7.3.

with the indicated experience obtained in several recent "sickness censuses" in the United States, to which reference has been made, and with the experience of the German sickness insurance system during the five years prior to the war. With similar waiting and benefit periods, the German experience for the years 1909–1913 showed an average of 8.4 days of compensated sickness per member per year. This was a considerable increase over the rate in 1900 and in years prior, which was about 6 or 7 days.[1]

[1] The following table presents the German sickness insurance experience for the years 1885, 1890, 1900, and 1905–1913 (compiled for the years indicated from Statistik des Deutschen Reichs: Die Krankenversicherung):

Year	Average yearly number of members	Cases of sickness and confinement	Days of sickness and confinement	AVERAGE NUMBER OF DAYS OF SICKNESS		Average number sick during the year per 1,000 members
				Per sick member	Per insured member	
1885	4,290,000	1,804,829	25,301,178	14.1	5.89	420
1890	6,579,539	2,422,350	39,176,689	16.2	5.95	368
1895	7,525,524	2,703,632	46,470,023	17.2	6.17	359
1900	9,520,763	3,679,285	64,916,827	17.6	6.82	386
1905	11,184,476	4,451,448	88,082,296	19.8	7.87	398
1906	11,689,388	4,423,756	87,444,605	19.8	7.48	378
1907	12,138,966	4,956,388	97,148,780	19.6	8.00	408
1908	12,324,094	5,206,148	103,894,299	20.0	8.43	422
1909	12,519,785	5,045,793	103,368,412	20.5	8.25	403
1910	13,069,375	5,197,080	104,708,104	20.1	8.01	398
1911	13,619,048	5,772,388	115,128,905	19.9	8.45	424
1912	13,217,705	5,633,956	112,249,064	19.9	8.49	426
1913	13,566,473	5,710,251	117,436,644	20.6	8.65	421

While the increase was in some measure undoubtedly due to changes in the provisions of the sickness insurance law, it can be interpreted at least partly as an indication of improvements in the medical care of the sick, of the placing of a greater emphasis upon "medical inadvisability to work" rather than on actual "inability to work" as a principle in determining the return of disabled workers to employment, and of a clearer realization of insured persons as to their rights under the insurance system. It would therefore appear that all of the increase cannot be attributed to malingering. Without venturing to assume that conditions affecting the health of German wage earners before the war were comparable in all respects with conditions in this country or that the German sickness rate is any guide to the sickness expectancy here, it seems reasonable to have under consideration the probability that the expectancy of sickness which is to receive cash benefits under State or other health insurance laws in the United States will be larger than that indicated by the experience of existing sick-benefit funds, especially if an adequate medical service is afforded.

Probably a conservative estimate of the total amount of sickness which will require medical service under the proposed health-insurance measures would be something between and days per insured person. This includes, of course, the first 3 days of sickness and sicknesses lasting less than 4 days for which medical service must be provided. With a sickness expectancy of 9 days per insured person per year, the physician with 1,000 insured persons on his list might expect to have 20 to 40 of these constantly sick. That would mean making some 20 to 40 professional visits a day, though a certain proportion will be office visits. This estimate applies only to insured persons; if the families are to be included in the medical benefits and if the average family consists of wage earner,

wife, and child, the amount of medical work would be increased at least 200 percent, for it may be safely estimated that the sickness expectancy in the family is at least twice as great as for insured persons

Methods of Providing Adequate Medical and Surgical Relief

The question of adequate medical relief has become a serious economic problem. The advances made in medical science, the new discoveries, the refinements in technique of diagnosis and treatment, have added to the seriousness of the problem, until now it is often stated that only the rich and some of the very poor are able to obtain the latest and most up-to-date medical and surgical treatment.

For the general practitioner the question of rendering his best service is becoming more onerous. The examination which he is now equipped for carrying out requires so much time and patience that it becomes a question of increasing his charges to where the cost is prohibitive for the man of ordinary income, or doing his increased service at the old rate of pay and finding that he is not able to earn a decent living for his family.

The physician, when he faces this situation, must decide to confine his practice to the well-to-do, to drop back into the old method of a hurried and inadequate service for a large clientele, or to render his best service to all and content himself in his poverty with the knowledge that his life is worth while.

In another sense an important underlying cause of the present medical and surgical service inadequacy is an economic one. The income of the physician is dependent upon the misfortune of his friends. When his friends are not sick the doctor's income stops. In other words, when his friends are without income they have the further burden of a doctor's bill. This is, to say the least, economically unsound. If the practice of medicine is to be on a sound economic basis the cost of sickness should be met during the period of employment, when there is an income. The problem, then, is to furnish an adequate medical and surgical service to the wage earner, the cost to be met during the period of employment. To guarantee that it be within the reach of all employed persons, provision must be made for the continuance of a substantial part of the income during sickness, else many will not be able to stop work even when sick. Under present practices of the medical profession there is a premium placed on sickness. That is to say, the patient who is sick often, or for long periods, is worth much more to his doctor than the patient who is seldom sick. This should be reversed; the premium should, in so far as practicable, be placed on health. With a premium on health payable to the doctor, it goes without saying that it would be an added incentive to him to keep his patients well, and to cure them as quickly as possible when sick. The question, then, is as to the practicability of working out some plan by which all of the good features in present practice may be retained and at the same time add an economic incentive as a further inducement for the doctor to keep his patient well.

If health insurance is to come, and changes in methods of medical practice are to be made, certainly the opportunity is an extraordinary one for placing these practices on an economically sound basis, and for making "sickness" insurance actually a "health" insurance.

It should be thoroughly understood that adequate medical and surgical relief is not possible without adequate pay. Any plan which proposes to reduce the average net income of the physician will surely fail to provide adequate relief. If, as is often stated, a large proportion of the people are not receiving adequate medical treatment, the readjustments made necessary in order to provide proper treatment for all insured persons would very probably mean an increase in the average net income of the physicians. Surely no plan should be countenanced which will make matters worse.

In this connection it is well for physicians to consider the experience of foreign countries under sickness insurance, and the experience of this country under workmen's compensation laws. In Germany, the plan of administration of medical benefits which led to the "doctors' strike,"* would hardly offer inducements to us to copy the German plan. In Great Britain, the plan has been the subject of much criticism, mainly because of the incentive to malingering, and delays in payments, and methods of payments to the physicians.

After the British law had been in operation for something more than a year, Mr. Lloyd George made the statement that there had been an average increase in the annual income of the physicians of $750 occasioned by the act, and that 22,000 of the 25,000 physicians in England had registered on the panels. The experience in this country under workmen's compensation laws is too well known to need discussion here. That this experience has not been satisfactory is mainly the fault of the physicians themselves. They sat quietly by while the laws were being enacted and made little effort to have the proper provisions incorporated into these acts. The question naturally arises, shall the physicians spend their time and money fighting these proposed measures, or shall they direct all their efforts toward working out satisfactory plans, and insist on their inclusion in all the bills proposed in any State legislature?

Turning now to the discussion of the plans for providing medical and surgical treatment, and the methods of payment, the following have been proposed:

1. The establishment of a panel upon which any licensed practitioner so desiring may register. From this panel insured persons are allowed to select their physician, subject to the right of the physician to refuse under certain regulations.

2. Contract physicians employed on an annual salary basis, or a capitation basis, from which number the insured persons are allowed to select.

3. District physicians, paid on part-time basis.

4. Combinations of numbers 1, 2, and 3.

The success or failure of any of these plans will, of course, depend largely upon their administration. Two plans for the organization of the administration have been proposed; one, with an administrative board composed entirely of employers and employees, with an advisory medical committee; the other, with an administrative board composed of a chairman, employer, and employee directors, together with a medical director and a health director, with an advisory medical committee. It would appear obvious that in the administration of medical and health matters, medical and health men should have an active part in the management instead of only an advisory authority. The State should have representation through the selection of the chairman and the health director, and physicians should insist on having proper representation on the local and district boards which are to administer the medical benefits, and not be satisfied with an advisory position.

As to the plans for providing medical benefits, it seems to be conceded that free choice of physicians must be provided wherever practicable. Whether this will always provide the best medical service is a question, but the demand of individual freedom in this matter is too strong to be limited, even though the individual may at times exercise this freedom of choice to his own detriment. Furthermore, the efficiency of a physician's treatment would be seriously affected when attending a patient who did not prefer his services. Much may be

*[Physicians in Cologne, in 1910, in a dispute with the sickness insurance funds, withheld services from the funds' beneficiaries. Ed.]

said in favor of freedom of choice. It would avoid a disturbance of the time-honored relation of the family physician to his patients. With the right to change doctors at will, physicians would still have operative all of the present incentive to please their patients.

It would be through the method of payment that an opportunity would be afforded to take the premium off of sickness and place it indirectly upon health. By fixing the payments on a capitation basis, the physician would receive the same amount per patient per year, whether his patients were sick or well. This would indirectly result in making the healthy patient the most desirable to the physician. Under this system there might be some patients left over who had been refused by all of the physicians as undesirable on account of the frequency of their demands on the medical attendant's time. This, however, is liable to occur under any system of free choice. If the number of these left-over patients is small, they may be allotted pro rata. If the number is large, a salaried physician may be employed to attend them. Surely when the patients have the power to change physicians at will, the physician will have the same incentive as he now has to please and render his best service. Furthermore, he will realize that by doing everything possible to keep his patients in health his work will be reduced. On a visitation basis of payment the physician who had sickly patients would have the better income, so that there would be no indirect financial incentive to keep his patients well; on the contrary, the more visits he made, the greater his income. This plan of so much per visit would probably be too expensive for the insurance system, unless in making up the annual budget a fixed amount were allotted for the payment of medical benefits. Such an allotment of a definite amount per insured person would really be equivalent to capitation payment, as it would limit the payment to a fixed amount per capita. It would, however, have the defect of putting a premium on the sick patient.

In this discussion of plans for providing adequate medical and surgical relief, the remuneration of physicians must be presumed to be adequate, else the conditions are liable to be worse under health insurance than they are now. For this reason it might be provided in the organic act that the rate of remuneration must be adequate, and provisions made for a commission to fix the rates. Furthermore, if members of the families of insured persons are to be included in provisions for medical benefits, the rates should be fixed according to the number entitled to medical benefits and not according to the number of insured persons. Obviously, the physician who is to furnish medical treatment to an insured person with wife and child is entitled to three times more than he would be if he is only to furnish it to a single insured person with no dependents, for, as stated above, the sickness expectancy of women and children is very probably as great as that of men in the wage-earning age group.

Before leaving this question of medical benefits it should be stated that it is not just to oppose a proper health insurance bill on the ground that it means cheap contract practice, with all of its known evil. Contract practice cannot be objectionable if the physician is paid enough so that he will not have to slight his work in order to make a living.

Contract practice is in successful operation in this country in many government services, and in many large business establishments. Furthermore, based on a capitation payment, where there is competition for patients, the contract practice is likely to prove satisfactory, provided always that there is no opportunity for cutting the rates of payments.

Methods of Adequate Prevention of Sickness—Plan for Making Sickness Insurance Actually Health Insurance

The foregoing discussion has related to sickness insurance as a relief measure. If it is to be enacted on the grounds of a health measure and is really to be health

insurance then ample provision should be made for the prevention of disease. It is not sufficient to create a financial incentive for the reduction of the sickness rate. Definite provision should be made for preventive machinery. Some of the existing State health departments are too inefficient to be depended upon. They should be strengthened, to meet the needs in this field. If millions of State funds are to be expended for health work, surely these funds should be spent to prevent disease, and not simply for relief.

With the appropriations for "health insurance" running into millions of dollars annually it goes without saying that legislative bodies will not materially increase the appropriations for their health departments. Owing to this fact there is a decided probability of sickness insurance acts endangering the very existence of State health departments by absorbing all of the funds available for health work. Our statesmen and lawmakers must therefore be careful that proper and ample provisions are made for health machinery in any sickness insurance act.

No provisions have been made in any of the insurance systems of foreign countries for coordinating them with the health agencies; though to a limited extent provisions are made by some for disease prevention and medical research. The English experience has been such that the ministry of health bill now pending provides for the transfer of the national insurance system to the health department.

We should profit by this experience and make ample provision for disease prevention through existing State health agencies. All proposals for health insurance in this country should therefore be carefully scrutinized and all sections providing for disease prevention amended so as to definitely place these functions under the jurisdiction of the health departments. Otherwise there will be duplication of work, confusion of administration and waste of funds. The weightiest of the arguments presented by the proponents of health insurance are based on the probable effect it will have in preventing disease. The question then would seem to be whether existing health agencies shall be utilized or new agencies created. Surely some plan can be worked out whereby existing health agencies can be coordinated with health insurance systems and obviate the necessity of creating new machinery. Even if new machinery were created it would be unwise to create it to work independently, so that, after all, existing health agencies would need to be coordinated with the new system.

The general outlines of a plan for coordination were approved by the Annual Conference of State and Territorial Health Officers with the Public Health Service, May, 1916. This plan proposes to utilize the medical referees in carrying it into effect. It is proposed to have these appointed by the State, and commissioned to act as referees for the health insurance system and as health officers for the health department, under the jurisdiction of both agencies.

Following out this general outline, a scheme of organization has been suggested which, it is believed, would work out satisfactorily to both. It is pretty well conceded that medical referees will be required in every locality to see and keep in touch with each sick person in order to certify to his disability prior to the payment of cash benefits. Experience has shown that it is not right to impose the duty of signing the disability certificate upon the physician treating the case. Since the medical referee is considered necessary in the scheme of sickness insurance, and since his duties as referee will require him to pass upon claims in which three parties are interested, viz., the insurer, the insured, and the treating physician, it would appear but proper that he be employed by the State. The additional duties required of him as health officer would not interfere with his usefulness as referee; in fact, they would add to his efficiency and clothe him with the authority of the health department. Such authority would make of him one unit in the health machinery for the health insurance system.

The organization proposed would be about as follows:

1. Make the State commissioner of health an ex officio member of the State health insurance commission.

2. Detail a medical director from the State health department to assist the commission in supervising the administration of the medical benefits and to act as health advisor and director.

3. Detail district medical directors from the State health department to aid in the administration of the medical benefits in their respective districts.

4. Detail from the State health department a sufficient number of local medical officers to act as medical referees and to sign all disability certificates, and to perform such other duties as may be authorized by law or regulation.

To give some idea of the size of such a corps, it may be tentatively estimated that it would require one medical referee to every 4,000 insured persons. In a state with 1,000,000 wage earners, this would mean 250 local medical officers giving their entire time to the study of the health of the insured persons. This, of course, would be in addition to the medical treatment furnished by the panel physicians.

The objection could not be offered that such a corps would be too expensive, for it must not be forgotten that all the measures now advocated provide for medical referees. The only additional expense incurred by this plan would be for the medical director and the district medical directors.

Even if the expense of the whole corps were an additional expense, the cost would not be prohibitive because the medical referees would more than save their salaries in the disallowances of unfair claims. Furthermore, while an estimate cannot be made of the amount to be saved by the work of these health experts, it is safe to say it would be many times more than the sum of their salaries.

At first glance this plan has been considered by some to be impracticable because they thought it gave too much authority to the health departments. It, however, does not add to the authority of health departments, it only extends their field of usefulness.

The duties of the referee as related to the insurance system would be to see and keep in touch with the sick insured, to certify to their disability, to advise with the treating physician, to advise the insuring agency as to measures calculated to shorten disabilities, and to prevent disabilities among insured persons.

The duties of the referee as related to the health department would be almost identical with the above, with the additional duties of sending duplicates of morbidity and mortality reports to the department, and advising as to any assistance he may need for research into the causes of sickness in his jurisdiction.

For the proper performance of these two sets of duties he would be responsible to each department. But under the organization proposed, a referee would receive State appointment, subject to duty anywhere within the State, so that if for any reason his services were not locally satisfactory he might be shifted to another locality; in fact, there should be a limit to his tour of duty in any one locality to prevent him becoming too thoroughly identified with the local politics or other conditions which might give a bias to his decisions or actions.

The plan has been criticized owing to the fact that it does not place employment of the referee under the control of the local insuring agency, one of the parties interested in his decisions as referee. It would seem obvious that a referee should not be employed by one of the parties at interest. Further criticism has been made that the treating doctors would not submit to supervision by a

representative of the State health department. It is hard to understand why they would object to the physician employed by the State but would have no objection to the same supervision by a physician employed by the local insuring agency.

In order to secure the best men for medical referees, it is proposed in the plan to require an examination, physical and mental, as to qualifications, and after a probationary period of satisfactory service to make the appointment permanent, subject to efficiency and good moral conduct. It is believed that the prestige of a State appointment, and the permanent tenure of office, will obtain better men at the same salary for these offices than employment by local insuring agencies on a contract basis, with the liability that the contract may not be renewed on its termination. Furthermore, organized into a State corps with central control and direction, with a strong *esprit de corps,* there would be developed a health machine protecting every home, consisting of men trained to see unhygienic conditions, with a vision for the total environment, and clothed with all the present powers of the health department to look into conditions that are liable to cause disease, and with such influence as the prestige of State appointment may give to their opinions and acts. ■

Seal of the Public Health Service
designed by Surgeon General
John M. Woodworth in 1872