of the country in the rates of morbidity and of deaths from certain causes. Accidental death, largely preventible, is the principal cause of death for the age-groups 1 to 14 years, and the second cause for the age-groups from 15 to 39 years. Tuberculosis, completely preventible, is the chief cause of death between the ages of 15 and 39 years and exacts a considerable toll among almost all other age-groups.

Conclusions

This is not an attempt to assess in dollars and cents the value of life or health. To regard these as commodities is to confuse economic ends and economic means. "There is no wealth but life," said Ruskin. The so-called money value of a man, computed by several authors from William Farr to L. I. Dublin, is only the assumed present worth of his net future earnings. Those figures are useful and interesting but they reflect only the price paid for certain services and not their value, even in a strictly economic sense. And man makes a far greater contribution to society than is expressed by his activities as a breadwinner.

But this is not to deny the importance of these activities. And if our level of production is to be maintained and increased, one of our principal considerations must be avoidance of incapacitation from illness. Money spent efficiently on the prevention of disease is not money wasted; it pays a tenfold dividend in the increase of the national wealth.

Voluntary Insurance For Comprehensive Medical Service

By Dean A. Clark

VOLUNTARY insurance for various types of medical and hospital care has been making rapid progress in the United States in recent years. Insurance for hospitalization, for instance, now includes more than 20,000,000 persons under the Blue Cross plans alone. But most voluntary programs in this country cover only a portion of the medical services people need. Typically, they are limited to hospitalization or to surgery and obstetrics or some other specific service. Because of these restricted benefits such programs are very incomplete, offer no preventive services, and at best have proven to be only partially satisfactory. On the other hand, the few programs that do furnish a broad scope of medical services on an insurance basis are usually limited to the employees of one industry or to the patients of a single group of doctors and thus are not available to the whole community. The Health Insurance Plan of Greater New York, however, will provide a comprehensive medical insurance plan, open to all groups of employees (and their dependents) who wish to join, and open to all groups of physicians who meet minimum professional standards and who desire to participate.

The provision of comprehensive medical service under voluntary insurance plans in this country has been attempted principally by two methods. One is through the payment of fees for each service rendered to insured persons, utilizing any physician whom the subscriber may happen to select. This is often called the "open panel" method. The other is through the use of specified physicians or groups of physicians—a "closed panel"—who are paid on a yearly basis in accordance with their training and competence and in accordance with

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the amount of time they spend in serving insured persons.

The first method—fee-for-service-open-panel—has not proved well adapted to the provision of comprehensive services, in the home, office and hospital. A cumbersome administrative organization is needed to keep track of the bills for a multitude of individual services and to exercise the controls necessary to see that fee-schedules are followed and bills paid only when services can be properly justified. Thus, when used for comprehensive services, the open-panel-fee-for-service method invariably results in controls and red tape which are irksome to both doctors and patients. These difficulties have been found not only in voluntary plans in the United States, as in the State-wide attempts in California and Michigan, but also in compulsory plans using the fee-for-service method, notably in France and New Zealand. In voluntary plans, however, the disagreeable controls necessary when fees-for-service are paid for comprehensive medical services have had an additional disadvantage: The controls have usually proved entirely inadequate to prevent abuse and keep the plans solvent. Most of the open panel attempts at voluntary comprehensive medical insurance in the United States have, therefore, been failures and have been obliged either to cease operations entirely or restrict themselves to services like surgical operations and obstetrical deliveries, which are relatively simple to verify and scrutinize.

The second method—group medical practice and payment by some means other than fees-for-service has been much more successful with the provision of comprehensive service. Such industrial plans as the Northern Pacific Beneficial Association, the Endicott-Johnson scheme, and such private plans as the Ross-Loos Clinic of Los Angeles and the Trinity Hospital of Little Rock have been in existence for many years on a sound financial basis, to the satisfaction of both patients and physicians. After study of previous attempts to provide comprehensive care, therefore, the HIP decided to follow the principles of the most successful of them and will be conducted through group practice, paid for by the capitation method, that is, payment of a specified amount per year to a medical group for each insured person enrolled with that group. This method makes it possible for HIP and for the medical groups to know in advance what income to expect and what expenses to plan for and thus to maintain financial stability.

Enrollment in HIP is voluntary. Only groups of employees earning base wages or salaries less than $5,000 a year and numbering 25 or more will be accepted, and each such group must constitute at least 75% of the employees in a given employment unit (a unit may be an entire business or some natural subdivision of it, such as a department or section). This percentage must also be maintained in order to continue membership in the plan. Employers must pay at least one-half of the premium. Dependents, limited by New York State Law to spouse and unmarried children under 18, may also be enrolled. Each person insured by HIP must also carry insurance for hospitalization. (HIP itself does not write hospitalization coverage, however.) These underwriting rules are to be strictly observed in order to assure HIP of a membership which includes a broad, stable cross-section of healthy and ill people as a sound basis for the use of the insurance principle. Plans which have neglected these elementary safeguards have invariably come to grief.

HIP is a non-profit organization incorporated under the New York State Insurance Law. Its 100 incorporators and 24 Board Members represent the major interests in the community: Business, labor, city government, social welfare, religious groups, as well as medicine and hospital administration. Benefits will include physicians' services—both general and specialist—in the home, office and hospital; laboratory services; phys-

ical therapy; X-ray diagnosis and treatment; refractions; visiting nurse services; and ambulance service. In addition to services for diagnosis and treatmen subscribers are entitled to periodic health examinations, psychiatric advice and consultation, immunizations, health education, and other preventive services. Except for the exclusion of drug addiction, alcoholism, and treatment by a psychiatrist, there are no limitations on the scope of service, on the age of subscribers, on pre-existing conditions, or on the duration of treatment — provided the premium continues to be paid. Subscribers who change jobs or for other reasons leave their enrollment group may convert to individual policies.

Medical groups are being organized by physicians in all boroughs of the city and in surrounding counties. Each group will include general physicians and specialists in at least the major fields of internal medicine, general surgery, obstetrics, gynecology, pediatrics, otolaryngology, ophthalmology, orthopedics, dermatology, neuro-psychiatry, urology, X-ray and pathology. Physicians may continue to carry on their individual practices while they are members of a medical group serving HIP patients, but they must agree to provide HIP subscribers with all the services they require. Although at the start of HIP not all medical groups will have complete medical centres from which to provide all their services, several groups will have small centres and every group will have an administrative office which patients may call at any time for service and which will maintain the group's records, etc. The professional standards of each medical group must be reviewed and approved by HIP's Medical Control Board, which will also decide all professional questions arising in the operation of the plan. The Medical Control Board is to be composed of 15 physicians of high professional qualifications, including representatives of the HIP Board of Directors, the participating medical groups, the five county medical societies in New York City, and the New York Academy of Medicine.

The highly developed skills and complex knowledge now available in medical science makes it impossible for any one physician to furnish competently all types of medical care. Thus balanced teams of physicians of different skills and the necessary assisting personnel are essential, in HIP's view, for good medical service to-day. Furthermore, many economies in overhead expense which may be passed along as lowered costs to patients and increased incomes to physicians can be achieved by medical groups through the common use of assisting personnel and of expensive equipment and facilities. Each person insured by HIP will have free choice of the medical groups in his area of the city, and will also choose one physician of the group to be his personal doctor. The personal physician will have general supervision over the health of the subscriber and his family and will, in addition, have the specialist and technical services of the group available for consultation and treatment when indicated. In this way, the family physician, new style, retains the close personal relationship of the old style family physician that is so essential for good medical care, but he also becomes the key man on a medical team that includes all the techniques necessary for the best application of modern medical science.

HIP will pay a medical group at the rate of $19.20 (eventually to be $20.00) a year for each insured person—man, woman, or child—enrolled with it. This capitation fee will yield an annual gross income of $16,000.00 per full-time physician (or his equivalent in part-time service), allowing an average of 800 insured persons per full-time physician. After overhead costs are met, it is expected that physicians' annual net incomes will average $10,000. Each medical group is an autonomous unit, however, and will itself determine the method and amount of the payments to its individual physicians.

Premiums for HIP are approximately $30.00 a year for a single employee,

$60.00 for a couple, and $90.00 for a family of three or more. Adding Blue Cross Hospitalization premiums brings the annual totals to $41.00, $82.00, and $120.00 respectively. If an employer pays at least half of these, as the City of New York and the United Nations have agreed to do for all their employees (and dependents) who wish to join, the most any family will have to pay for full service is thus $5.00 a month. HIP services began March 1 of this year.

In its essential principles, the pattern being established by HIP is, as indicated previously, an old one in the United States. But its use on a community-wide scale is new and will provide a demonstration worthy of the attention of other localities. With adequate financial backing (which in the case of HIP has been furnished by three Foundations) a similar medical care plan might well be established in any community located in a State where the laws would permit this type of organization. This pattern offers an opportunity for the medical profession and the public to demonstrate that comprehensive medical service can be furnished on a sound insurance basis. Insurance for a broad range of services combined with group medical practice will, HIP believes, go far toward helping attain better distribution of top-quality medical care.

State Medical Service in Britain

By E. Clayton Jones

EDITOR'S NOTE: While Britain's new national health program was before Parliament, PUBLIC AFFAIRS published (in the issue of September, 1946) an article dealing with the general principles embodied in the program. It has meanwhile been put on the statute books and this article, written by a British physician, describes the organization of the new services.

THE National Health Service Act, which gives Britain's Minister of Health, Mr. Aneurin Bevan, powers to set up a free comprehensive medical service for everyone in England and Wales (a similar Bill has since been introduced for Scotland) reached the end of its lively voyage through Parliament last November and so became law. The "appointed day," when its provisions will begin to take effect is expected to be April 1, 1948.

Though this Act has been passed when a Labour Government is in power, and though its nationalising function is one of the main platforms of the Labour Party's policy, it represents the culmination of the efforts of successive Governments, for a scheme for a national health service was first outlined in a Parliamentary White Paper by the Coalition Government in 1943. The schemes differ in some administrative respects, particularly as regards hospital and specialist services, but have a great deal in common.

The Act deals only with the main structure of the new services, leaving details to be filled in later by means of regulations which will be subject to the control of Parliament. It is in effect an enabling Act, erecting a framework into which the Minister of Health hopes, with the help of his staff and representatives of the medical profession, to fit a workable and generally acceptable medical service.

The framework of the scheme was described in a Government White Paper in March, 1946, and though it has since been more or less continuously under fire from its critics, both inside and outside Parliament, the broad design remains unchanged.

Universal Availability

Unlike the present "panel" doctor service, which supplies medical attention for a strictly limited class of patient—