a period of two months. This allows a little time to see what will happen. If adequate R. F. C. and state funds take the estimated increase in relief load from private funds, the cut need be only temporary. If they do not, a whole range of services will be seriously impaired at the time when the community and its people need them most.

The chest in Washington, D. C., likewise fell short by half a million. Instead of an immediate cut of agency budgets the chest has added half a million to the estimates of needed public-relief funds to be asked of Congress. If the appropriation fails, the relief deficit will probably have to be absorbed at the expense of other services.

It is not only private services that are endangered. Some of our hard-won gains in public welfare are threatened with the knife. From certain up-state New York counties come reports that short-sighted local economists have discovered that it is cheaper to put a mother's-aid case on direct relief than to treat it through the approved methods of the established board of child welfare. The state reimburses 40 percent toward direct relief; it reimburses nothing on account of mothers' aid. By transferring the case the county saves itself some money, but the total relief fund is not increased and a principle is abrogated. As this is written, the governor of New Jersey is proposing to transfer the state's old-age relief cases to the Emergency Relief Administration, thereby cutting into funds available for unemployment relief and changing the pattern of a service which was difficult to establish and which will be difficult to restore.

Within the next few months some forty state legislatures will meet. The immediate fate of our whole relief and welfare program seems to me to rest with those state bodies. Under these circumstances the R. F. C. policy toward state participation, is necessarily becoming more exacting. Most of the states anticipating R. F. C. funds for relief will be obliged to come to the Corporation for additional funds while their legislatures are actually in session. The R. F. C. in its instructions to governors has indicated that pressure for state action will be exerted. Procrastination, log-rolling and alibis will not stand. The winter's bitter necessities are steadily rising and local community resources are falling. We have available a considerable body of experience in state-relief administration to indicate the direction which state action should take if it is to utilize to the utmost R. F. C. funds, to increase total relief funds, to strengthen effective administration and to save our vital community services from dismemberment. The key to the whole immediate situation seems to rest with those forty state legislatures. Prompt and vigorous action on their part will break the vicious circle in which our whole relief and welfare program is caught.

Consumers of Medical Services

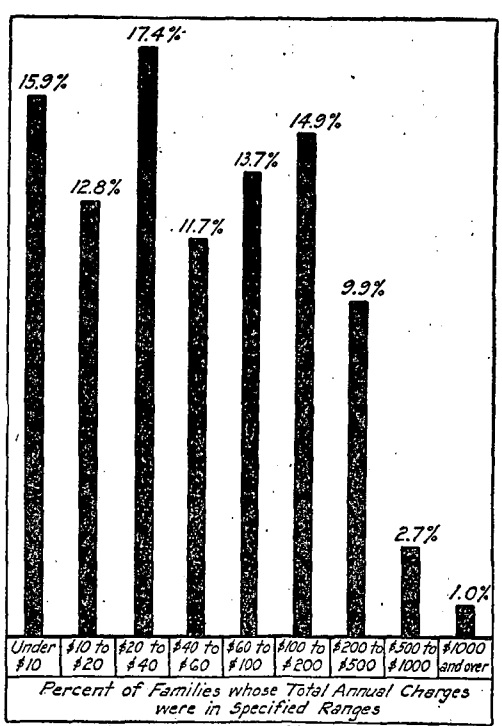
By JAMES P. WARBASSE, M.D.

President the Cooperative League of America

THE time was when a single doctor could encompass pretty much all of the knowledge and art of medicine. That was in the days of the good family physician. Now nobody can know it all nor skillfully practice the whole of that art. On the other hand, industries have been intensified and united in the interest of efficiency and economy. But medicine is still carried on much as was industry in the days of the hand-loom.

The sick man who seeks medical advice goes from one place to another collecting the information on his case until he has assembled enough to tell him what the trouble is or what may be done to make him well. This method is so expensive that only the rich can afford it. Medicine has much to offer, but the average patient can not buy all of its advantages. He usually dies without them. And the average doctor has to earn a living and cannot afford to give the average patient all of the benefits of medical art. As a result, the costs are so great that people defer sending for the doctor until disease is well established, there is an unnecessarily high mortality, and in the end the doctor is poorly paid for his services. There are exceptions; this is the rule.

Still more deplorable is the fact that medical knowledge, the accumulation of the ages, acquired out of the suffering and deaths of our ancestors, is treated as private property and peddled by doctors competing for business with one another like tradesmen in the market places.



Charts by Courtesy Harper & Brothers

The uneven burdens of illness

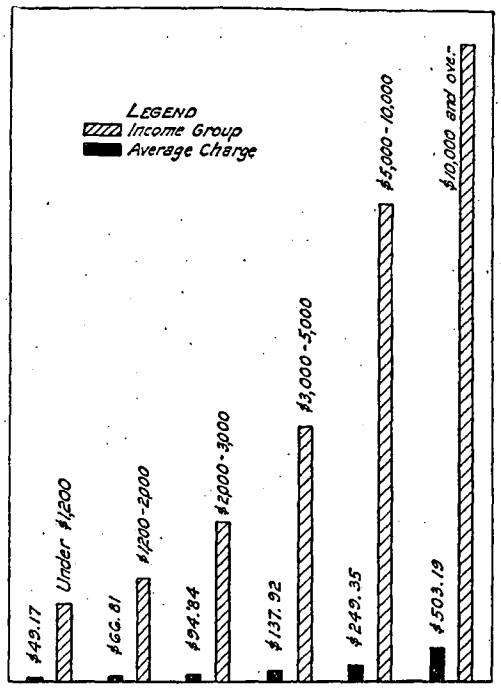
These deficiences are slowly remedied. Centers for group action are developing. This is seen in hospitals and clinics. To make medicine more accessible to all, the state is more and more supplying the need. Consumers' societies, medical syndicates and guilds, insurance associations, corporations, trade unions, fraternal organizations and many other groups representing patients and doctors have arisen in the interest of each.

The new book by Evans Clark[1] deals with this subject. This book describes the defects of the competitive method in medicine. Much information on group practice is collected. The costs of medical care

[1] *How to Budget Health*, by Evans Clark. Harpers. Published under the auspices of The Twentieth Century Fund, founded by Edward A. Filene. 328 pp. Price $4 postpaid of The Survey.

and the incomes of physicians are analyzed. Mr. Clark wisely says: "So acute is the problem and so grave the dissatisfaction with existing facilities that the compulsion of the state may be invoked before private and voluntary action has had a chance to demonstrate its own capacity."

While medicine is the most radical of the arts, the medical profession has never applied to its own conduct the scientific methods which it employs in solving biological problems. The physicians, while applying scientific methods to the diseased human body, refuse to use those same methods in solving the problems of a sick social body. They insist on employing emotion in place of science and on following the methods of the business world which have brought humanity into a morass of distress.



Medical bills vs. family income

We learn from this book that the total plant investment in equipment for medical service in this country amounts to nearly six billion dollars, that about one third of the deaths are preventable, that the majority of people have some pathological condition, that the ratio of physicians to population varies from 1 to 282 in the District of Columbia to 1 to 1431 in South Carolina, that doctors in the United States have an average net income of about $5000, that the incomes of most doctors are less than $2500, that the average expenditure per family for medical service and materials is $108, and that doctors have difficulty in making a living from the patients they treat and that patients have difficulty in getting the treatment they need.

Mr. Clark shows that medicine, in the United States, in terms of number of personnel and value of service and capital investment, is only exceeded by five other industries. That means, with its 143,000 physicians and the expenditure by the people of nearly four billion dollars for medical service, medicine is an important business.

The plan of organization recommended is the guild method, exemplified by groups of doctors such as the Mayo Clinic, with the addition of periodic examinations and a fixed annual fee. Control by the doctors is stipulated. This is to be seen in process of development in all parts of the United States. It is in line with the natural tendency of economic combines and mass production and certainly corrects many of the disadvantages of the prevalent competitive system. Where doctors are thus united, the patient is spared shopping about from one expert to another, records and facilities are grouped at a focus, consultations are facilitated, bookkeeping and costs are reduced, treatment is closely related to diagnosis, and time is saved. One of the most important results is that doctors are removed from economic competition with one another; their fiscal interests are pooled and each takes out of the profits his stipulated share.

There are doctors who fail to realize that they live in a changing world and would fight to maintain the expiring system. They go so far as to assert that such group medicine is detrimental to the best medical standards, subversive and revolutionary. They do not see that it is they who are promoting revolution; for what is called revolution is but the decay of a dominant system and the chaos associated with its collapse.

Mr. Clark favors the syndicalist principle so often tried and so often found wanting. Workers' control has been attempted in the mediæval guilds in Europe, in the self-governing workshops, the workers profit-sharing or cooperative producers' industries in Great Britain, and in the more recent attempts of the syndicalists in Italy and France. Workers' control, whether in commodity or service production, is profit business. If the business prospers there has always been the disposition in the industrial guilds to hire service which was not permitted to share in the profits and control. The same thing is observed in the medical guilds. The business, develops from classes, seeking their own economic advantage from the community.

The only sort of industry that is conducted for service and not for profit that is not carried on by the state, is some form of non-political organization of the consumers. This latter is found in the consumers' cooperative societies. These organizations have developed medical service to a high degree of perfection. Their successful medical institutions are to be seen in many countries. Their clinics, sanatoriums, laboratories for research, and hospitals are fine examples of medical practice and health protection. In these institutions the ownership and control rests in the patients and the prospective patients—the consumers—who can be expanded into the whole of society. The physicians are of a high class and are organized in workers' guilds to protect their own interests and standards. These health services are not isolated but are directly connected with the more significant agencies of health—the supply of food, housing, recreation, education, insurance, and pensions, and the general economic life. Consumers' cooperation is not a theory but a steadily growing system. More than 230,000 of these societies, with 70 million members, in 42 countries are united in an International Alliance. Their efficiency should not be ignored.

The plan offered by Mr. Clark can be taken by a community of people who wish health protection, and applied by them to the organization of the doctors for the service of the community. The people have to pay all the bills, they are the employers, and they and not the employes are best fitted to control.

The consumer has been forgotten long enough. It has been private and privileged interests, doing things for and to the consumer, that have brought the world to the pass in which it now is found.

This book is rich in information. Its defense of the report of the Committee on the Costs of Medical Care is admirable. It will serve in helping toward an understanding of the social medical problem. The ideals which it holds up and its practical facts are needed at this time when reorganization of the economics of medicine is imperative.

Cleveland's Clinic Plan

THROUGHOUT the country hospitals and clinics are facing the questions charted below in an appeal from the United Hospital Fund of New York City: Must they turn away the sick poor, or lower standards, or can some way be found to meet the widening gap between income and costs? For the group of hospitals in nine areas reporting to the Federal Children's Bureau patients' payments in 1931 shrunk 8.6 percent from the 1930 figures; they constituted only 40 percent of institutional income, leaving 60 percent to be borne by dwindling public funds and endowments or by private givers. Patients' poverty is putting a heavy strain also on the incomes of doctors in private practice, which dropped 20 percent in 1930 and further and faster in the first quarter of 1931 according to figures compiled by the Committee on the Costs of Medical Care.

Facing immediate dilemmas raised by such facts as these and also the long-range problems of constructive relationships between physicians, social workers, patients and clinics, Cleveland adopted a new plan for dispensary admissions on July 1, 1932, following six months' conferences between Academy of Medicine, Welfare Council and Hospital Council. The intention is that the social agencies shall make use of the private physicians for patients who in normal times would make acceptable arrangements with a private doctor.

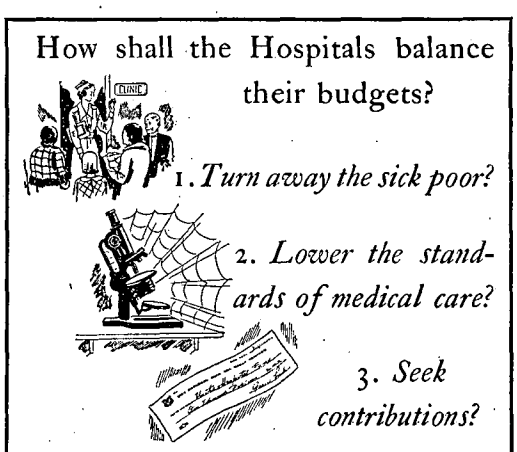
Under the plan social workers in the agencies and the outpatient departments of the hospitals agree that all new patients applying for clinic care will be referred back to their private physicians if they have had them. (No time limit is set; the social worker uses her discretion.) If the patient has not had a private doctor but may be able now or ultimately to pay something toward private care, he is referred by the social worker to a neighborhood physician listed by the Academy as willing to cooperate in the plan. The social worker gives the patient a slip to take to his family physician or a physician on the list. The doctor may treat the patient for the fee which he and the patient agree upon as fair; or he may treat the patient without cost or on a basis of deferred payment; or he may sign the slip and refer the patient back to a dispensary if neither of these courses is adopted. A Central Committee, composed of representatives of the Academy, the Hospital Council, Welfare Federation and Jewish Welfare Federation handles the traffic and passes on individual problems submitted by social worker, patient or physician as need arises.

Sufficient time has not yet elapsed to give conclusive answers as to the results of the plan. In answer to letters of enquiry recently sent out by the Welfare Federation, Dr. Harold J. Knapp, commissioner of health, declares that the Division of Health had found it "reasonably satisfactory." C. S. Woods, superintendent of St. Luke's Hospital, writes, "Our experience has convinced us that it preserves every important prerogative which the dispensary possesses. We are led to conclude that it is advantageous to the patient, to the physician and to the public." P. J. McMillin, superintendent of City Hospital, finds that while some patients hesitate to return to physicians to whom they already owe money, in general the plan has worked well, as does Margaret E. Hull, home-service secretary of the American Red Cross, on the basis of limited experience. Lucille K. Corbett, secretary of districts for the Associated Charities, writes that "the district secretaries are inclined to feel that the plan is working out satisfactorily" though they have had some difficulty in obtaining dental care and medicines prescribed by private physicians, and there is more inertia of the client to overcome in this process than in the somewhat simpler procedure of direct reference to a clinic.

Mrs. Charles W. Webb, director of the social-service department at the University Hospitals, believes that the plan has encouraged mutual understanding between doctors and social workers, and helps to keep up "a normal doctor-patient relationship with those patients who can and should maintain it." Mrs. Webb and Dr. H. L. Rockwood, director of Mount Sinai Hospital, raise the query of what is happening to the patients referred to private doctors and not re-referred to the clinic: are they actually getting care, or have they dropped out somewhere along the line? A study of this sort, following up 150 patients, is now under way.

H. Van Y. Caldwell, executive secretary of the Academy of Medicine reports that sampling of the forms sent to the Central Committee and contact with individual workers indicates that about 24 percent of the patients sent to private physicians by dispensaries and other agencies are being returned to dispensaries, leaving approximately 75 percent "who, we hope, are being kept by the private physician."

"The reception accorded the plan by individual physicians varies," Mr. Caldwell writes, "but apparently in most cases the physician is cooperating willingly. There have been no serious complaints and no large number of complaints either from patients, agencies or physicians. Several individual problems have arisen which have required individual decision. The new admissions to some of the dispensaries have decreased considerably. This may be due to one or all of three factors: adoption of the present admissions plan, adoption of other methods at the dispensaries to eliminate a percentage of admissions and another unusual drop in the sickness rate in Cleveland. Apparently the primary purpose of the plan is operating, namely: to help decrease the burden or load on dispensaries and to bring back into the practice of the family physician a large number of individuals who otherwise for one reason or another would have become dispensary patients." Medical societies of Akron and Canton, Ohio, are seeking adoption of this plan in their communities.



United Hospital Fund of New York City