

HEALTH SERVICE ORGANIZATION IN WESTERN EUROPE¹

MILTON I. ROEMER, M.D.²

SO MUCH of America's cultural heritage derives from Europe that it is small wonder that health workers in the United States have been interested in developments there. Social trends in the Old World have so often marked out the paths of change in the New World that a study of the organization and problems of European health services can shed much light on the meaning of events in the United States. It was with this motivation that a party of 14 American professional people³ undertook a brief but intensive study of health service organization in England, Sweden, Switzerland and France, during the summer of 1950.

Although the schedule allowed only about seven days in each country, practically every morning, afternoon, and evening were scheduled with visits to ministries of health, medical associations, hospitals, health departments, private physician's and dentist's offices, special clinics, nurseries, medical and nursing schools, agencies of social security, voluntary health societies, international organizations, or ordinary people in every walk of life. Fortified by the rich body of literature on European medicine, it was possible to get a picture of the general framework of health services in the nations visited and to draw certain comparisons with conditions in the United States.

EUROPE'S SOCIAL BACKGROUND

A few simple, basic facts about Europe have tremendous im-

¹ This report is based principally on observations during a survey in August-September 1950, sponsored by World Study Tours (Columbia University Travel Service).

² Yale University, Department of Public Health.

³ The party consisted of four physicians (a general practitioner, a specialist, a full-time public health administrator, and a teacher of public health), two private dentists, a nursing supervisor in a mental hospital, a podiatrist, two general social workers, a medical social worker, a research worker from an insurance company, and two medical economists from the Federal Government (the Social Security Administration and the Bureau of the Budget).

pact on health service organization. Some of these are so obvious to the American visitor that their great importance may be overlooked.

First, relative to the United States, Europe is old. The organization of society toward the solution of individual problems has proceeded for centuries; collective efforts have grown more extensively than here in every field. Leaving aside the full-blown communism of Eastern Europe, the economies of Western Europe have become increasingly socialized. In Great Britain there is the vast domestic program of the Labor Party, involving national ownership and operation of transportation, public utilities, coal mining, and now the basic steel industry. In Sweden, co-operatives have been a basic feature of the economy—in both the production and consumption of goods—for over a century. In Switzerland, co-operatives have also figured prominently and the all-important transportation system is nationalized. In both these countries, co-operative non-profit enterprises are fostered and subsidized by government. In France, the individualistic tradition runs deeper, but there is still a system of Social Security far more sweeping than ours.

Second, relative to the economy of the United States, Europe is poor. Its natural resources in land, metals, timber, chemicals, coal, oil, and (except for Soviet Russia) manpower are much smaller than ours. For centuries most of its nations have depended on the exploitation of “underdeveloped” areas of the earth, and colonial empires have been fading away. National rivalries have long stifled the development of free trade, and currently the East-West political conflict has added new barriers to the exchange of raw materials and manufactured products. European cities, industries, homes, and people have been devastated by two World Wars in a generation, not to mention the centuries of lesser wars before these. By comparison the wastage and destruction of American resources caused by wars have been trivial.

Third, relative to the United States, Europe is small. Millions live in areas which on this side of the Atlantic contain only

thousands. While there are sharp differences in nationalities and national traits, people are thrown together. A few hours' travel brings one into another nation and another culture. As a result, there is an extremely active exchange of ideas. People love to talk; the "strong, silent type" is not so popular. Arguments are not regarded as impolite, but as stimulating; yet there is great courtesy and it seems genuine. In this setting, although the force of tradition is great, new ideas grow rapidly—ideas in art, science, philosophy, and politics.

Fourth, relative to the United States, Europe has suffered. In recent years, virtually every family has been struck by tragedy. The suffering has been so deep and has affected so many millions of people that there is a demand for security far greater than in the United States. Europeans look for compensations to their sufferings and their discomforts through art, music, literature, travel, wine, good conversation. But they also seek various forms of assurance of economic security, through collective action. It is this search that leads Europeans now to various social programs, including measures for medical care. The suffering of Europeans has made them politically mature; the percentage of the population voting in elections is far higher than anywhere in the United States. The average citizen is sensitive to political issues, reflecting as they do social problems and collective ways of meeting them.

It is against this social background of Europe's relative age, its small size, its poverty, and its suffering that one must view and evaluate the structure and trends of health service organization. Observers who evaluate European medicine on the basis of bland comparisons with American medicine give conclusions no more scientifically accurate than an evaluation of the attributes of two plants without regard to the climate and soil in which they grew.

ECONOMIC SUPPORT FOR MEDICAL SERVICES

Throughout Great Britain, Sweden, Switzerland, and France, the economic support for medical and related services has become predominantly (though not entirely) socialized. The

term "socialized" is used in its broad sense to mean: organized by group action, whether governmental or voluntary. It encompasses governmentally controlled financing whether by the device of social insurance or general taxation. Historically considered, these various forms of group financing—that is: voluntary insurance, compulsory insurance, and general revenue support—vary only in degree, each representing collective rather than individual economic arrangements, and one form leading frequently into the other. Only a minority fraction of total medical care costs remain to be borne through personal, individual responsibility in Western Europe.

Yet, there are great differences in the approach to the social support of medical care costs. Great Britain, after a limited program of social insurance from 1911 to 1948 (financing general practitioner services for employed workers), has now gone farthest in socialized financing—almost as far as Soviet Russia and the countries of Eastern Europe. Virtually all medical services for the entire population are financed collectively; about 90 per cent through general revenues and 10 per cent through social insurance. In Sweden and in Switzerland, there are combinations of widespread voluntary insurance financing through local plans and general revenue support, somewhat along the lines of recent legislative proposals in the United States. In France there is a combination of national compulsory insurance and general revenue support.

Important distinctions must be made in the description of the financial support for hospital services, as against ambulatory medical care. The proportion of general revenue support for the former tends to be much greater than for the latter. As will be seen, the entire sphere of hospital services, including both the financing and the pattern of organization of professional services, has been subjected to much more social control than have the services of physicians in the home or office. Ambulatory care is associated more with the individual entrepreneur and contributory insurance financing.

The line between governmental and voluntary group action

is much less sharp in Europe than in the United States. In Sweden and Switzerland, for example, the insurance plans for physician's care are voluntary. The plans are organized on an area basis, rather than by occupation or industry, and administration is in local non-governmental hands. But these plans are heavily subsidized by government, in Sweden by the national government and in Switzerland by the canton or state governments. In Sweden, the premiums for membership in voluntary "sickness funds" are fixed (not varying with the subscriber's income), but about 50 per cent of the total costs of benefits is supported by government grants; this allows premiums to be quite low, offering little impediment to the enrollment of low-income persons. As a condition for receiving these grants, the plans are closely supervised by the government with respect to their rules of eligibility, extent of benefits, administrative procedures and so on.

The voluntary insurance plans give substantial but not complete protection against the cost of medical care. In Sweden they encompass only about 70 per cent of the population and in Switzerland about the same. There are various restrictions to membership, similar to those of voluntary plans in this country; the Stockholm plan, for instance, excludes initial enrollment of persons over 50 years of age and denies benefits for the care of pre-existing conditions. The full cost of physician's care, moreover, is not provided. In Sweden and Switzerland, the plans indemnify the beneficiary for two-thirds or three-quarters of the doctor's fees (for home and office service) according to government-approved fee schedules. Even in France, where the insurance is compulsory and nation-wide for all employed workers, the Social Security fund reimburses the worker for about 80 per cent of medical and hospital fees; in practice, it often amounts to less than this since doctors are permitted to charge fees in excess of the established schedules. Requirement of these partial payments by the patient is designed to discourage abuses, but it may discourage the procurement of needed services by low-income families. Only in

Great Britain is there complete freedom from financial impediments to medical care.

It is especially interesting to American observers to discover that voluntary insurance plan directors in Sweden have no objection to a system of compulsory enrollment. They would actually prefer it, believing that only in this way could protection be given to the entire population. Many healthy young people—good insurance risks—now fail to join plans, thereby compelling restrictions on “bad risk” persons for actuarial reasons. Compulsory enrollment requirements would not drive the voluntary plans out of business, but would give them a larger job to do, as was the case in the earliest compulsory health insurance program in Germany (since 1883) and in England from 1911 to 1948.

The present coverage of the Social Security program in France is a great extension over the pre-war program, covering the entire employed population in the cities and their dependents. A separate comprehensive health insurance program covers agricultural workers, but all self-employed persons must depend on voluntary insurance. Since the war, Sweden too has passed a law which would encompass not only employed workers but the entire population under a compulsory health insurance scheme. The law was to have been effective in July, 1950, was postponed to July, 1951, but now has been further postponed indefinitely. The law would levy a small fixed insurance tax on all persons, regardless of income, but most of the cost would be borne by general revenues. It is now felt that the cost would be excessive and the nation cannot “afford it.” Is this attitude related to the fact that Sweden did not take part in the Second World War and that its people did not suffer? Great Britain also knew that its National Health Service would be expensive—and it proved even costlier than anticipated; yet the money has been appropriated without any significant opposition. The British people had suffered greatly and the demand for health security was enormous—enough to justify, in British opinion, the extremely high taxes involved.

HOSPITALIZATION AND AMBULATORY CARE

The social organization of hospital services in Europe has proceeded along very different lines from that in America. In the United States, the general hospital has been in the main an extension of the private practice of medicine. It has been regarded largely as the "doctor's workshop" where the physician takes his private patients who are seriously sick. In the average American community, the great majority of doctors have "hospital privileges." This has been undergoing gradual change here, with the crystallization of the specialties and tightening of hospital staff organization, the extension of governmental institutions, the development of great teaching centers and regional hospital plans, and so on. In most towns, however, the general hospital is still a part of the world of private medical practice.

In Europe, from the beginning hospitals have been predominantly public institutions. In Sweden and in Switzerland, nearly all hospital beds are in institutions owned, operated and largely financed by units of government, usually local authorities. In France, while there are many voluntary institutions, most of the general hospital beds are in public facilities. Moreover, the voluntary hospitals have operated very much the way public hospitals do here, the great majority of their patients getting "ward care" paid for by combinations of insurance, general revenue, and charity. In England, long before the National Health Service Act, the proportion of general beds in governmental hospitals exceeded that in voluntary institutions and was continuing to rise; the pattern of care in voluntary hospitals was like that in France. Since July, 1948, virtually all British hospitals have come under complete governmental control. Being costly, general hospital services in Europe have been largely assumed as a public responsibility, like grade school education or, indeed, hospital care for tuberculosis and mental disorder in the United States.

With the overwhelmingly public character of European hospitals, medical staff organization is naturally quite different

from that in America. In Great Britain and Sweden, nearly all medical and surgical services in the hospitals are rendered by organized staffs of salaried specialists. This is hard for many American physicians to believe, so closely is the hospital tied to private fee-for-service medicine in our country. In France and Switzerland this is not the general rule, although a growing proportion of in-patient care in the governmental general hospitals is performed by salaried men. When professional services in the hospital are rendered by private specialists in France or Switzerland, the patient seldom pays a private surgical or medical fee. A general payment is made to the hospital—usually from the insurance system—and the physician is paid a relatively small annual honorarium (part-time salary). Only a small percentage of physicians have any direct access to the hospitals, either governmental or voluntary. The patient is cared for by the physician who is “on service” at the time, as in the average ward service in the United States.

The sharp separation of general practitioners, constituting the majority of physicians, from the hospitals is a source of dismay to many American observers. The “closed staff” is far more tightly closed than here. From the viewpoint of maintaining a high level of medical performance in the general practitioner, his isolation from the stimulating influences of the hospital is surely unfortunate. But there is a good side to it: the level of professional work in the hospitals is high. As a rule only well qualified specialists render service and there is assurance that the patient is getting expert care. Patients do not seem to object to the loss of free choice of doctor that hospitalization and care by a specialist usually means. A small proportion of people, perhaps less than 5 per cent, insist on free choice of specialist and can pay the private fees for care rendered, usually in a “nursing home,” outside the public medical system or the insurance system. Most important, the European patient seldom if ever has to avoid needed hospitalization because of the institutional and professional costs involved.

In Sweden, the public hospital system is particularly well

developed. Less tied to tradition than England or the continent, Sweden has erected some of the most magnificently functional hospital structures in the world. About 90 per cent of the cost of service is borne by the tax funds of the Swedish cities or counties, and only 10 per cent by the patient. This 10 per cent charge, moreover, is usually paid for the patient by his voluntary insurance society or, if he is indigent, by a welfare agency. Yet, in the new Swedish hospitals one does not see huge wards with impersonal management of cases. In the great South Hospital, Stockholm's newest, the largest wards contain four beds and there are many rooms with only one and two beds. The choice of a room is not made by the patient, in proportion to his affluence, but by the doctor, on the basis of the medical needs of the case. All services are rendered by salaried specialists and an active research program is conducted. These policies symbolize the general trend of hospital services in Europe.

Despite this high degree of organization of hospital services, physicians' home and office care in Europe is rendered predominantly along individualistic lines. While the insurance systems have organized economic support collectively, the pattern of care for ambulatory patients is based on private office practice. Polyclinics attached to hospitals are busy because patients can get specialist services in them without paying the charges left uncovered by insurance benefits (since indemnification is 80 per cent or less in France, Switzerland, and Sweden). The great bulk of care for ambulatory illness, however, is rendered by family doctors who receive private fees for each unit of service. In Great Britain, general practitioners are paid on a capitation basis and practice in private offices, even though financial support is almost entirely from general revenues.

PUBLIC HEALTH ADMINISTRATION

Administratively, the organized programs of medical care—both hospital and ambulatory—are quite separate and distinct from public health activities. The governmental or voluntary

agencies responsible for supervision of the medical care or social insurance programs are different from those providing preventive health services. Theoretically, this seems unfortunate, but it follows from the separate historical origins of the two movements. Medical care insurance programs grew from the experience and demands of the labor movement; social security was a response to the insecurity of the industrial worker dependent on wages and faced always with the hazard of unemployment. Hospitals sprang from the public welfare movement, an outgrowth of monasteries and almshouses for the care of the sick poor; they were part of the charitable tradition of Christianity to help the unfortunate. Public health, on the other hand, had foundations in general community development, as urbanization created problems of crowding and spread of communicable disease. It was not tied so closely to the labor movement or to charitable efforts for the poor. While the early public health thinking, prior to about 1870, was motivated by efforts to improve the lot of the lower economic classes (Frank in Italy, Chadwick in England, Pettenkofer in Germany)—including improvement of housing and working conditions—after the rise of bacteriology, it acquired more technical foundations in engineering, immunology, statistics, and legal restraints.

As a result, it is not surprising that public health services, hospital services and health insurance should have generally distinct administrative frameworks. This is unfortunate because certain opportunities are lost for preventive medicine. The insurance programs have become largely fiscal operations, with few active measures to prevent disease, and the hospitals likewise do little in way of case-finding (tuberculosis, venereal disease), health education, or other preventive services. Yet, despite the administrative dichotomy, the basically preventive value of any medical care program should not be overlooked. The elimination of economic barriers to early medical attention has great preventive value, especially in the control of chronic illness. Considering the overwhelming importance of the

chronic, degenerative diseases, compared with the acute infections, programs providing easy access to medical and hospital care in Europe, as well as in America, have perhaps greater preventive value than anything else within present knowledge.

A partial exception to the dichotomy of public health and medical care administration is found in Great Britain, where at the national level all health services are centralized in the Ministry of Health. The unity virtually stops here, however, for at the local level throughout Britain, the administration of medical care and public health under the National Health Service is divided among four separate agencies. Public health services are administered by the local Medical Officers of Health, as prior to the National Health Service Act; general medical and dental practitioner services are administered by newly organized local Executive Councils; hospitals and specialist services are under Regional Hospital Boards; and the large teaching hospitals (associated with medical schools) have a separate administrative framework. While the local Medical Officer of Health makes some effort to coordinate services, it is obviously difficult under such separations of authority. Critics of the unwieldy character of the National Health Service organization sometimes overlook the fact that this divided system was not the wish of the government and especially not that of the Ministry of Health. It was set up in this way to satisfy the demands of special professional groups: the general practitioners of medicine and dentistry, the specialists, and the medical educators. Compromise yielded complexity in administration and correction of the problems would require a more radical, rather than a more conservative approach.

In Sweden, while public health and health insurance programs are administered by separate agencies, there is some integration of preventive and treatment services at the point of delivery of clinical care in rural areas. The great problem of attracting doctors to the rural stretches of Sweden has been tackled through a system of rural medical officers. These physicians are paid a governmental salary for providing public

health services—such as immunizations, school health examinations, operation of well-baby clinics, attendance of communicable disease cases, etc.—and for treating the poor. They may also engage in private and insurance practice. One of these rural medical officers is available for about every 3,000 to 5,000 people. While this seems like a poor ratio in terms of American standards, the effectiveness of the Swedish physician is extended greatly by three circumstances: (1) an excellent system of public health nurses (about 1 per 2,500 people—far more than we have in the United States nationally) for home visiting and auxiliary medical services; (2) a much greater supply of hospital beds, both rural and urban, than in America, saving the doctor considerable travel time; (3) coverage of larger population units of about 75,000 with full-time “county” public health officers for sanitary, administrative, organizational, and educational duties.

To risk a large generalization, public health activities in Europe seem to be deeper than in the United States, though not so broad. The public health agencies do fewer things, but they do them more completely. English and French well-baby clinics, for example, are said to reach 80 per cent of the infants born in their areas. In the United States, an excellent program may reach 20 per cent of the babies, the rest being seen by private physicians or getting no systematic attention at all. The same sort of general comparison applies to tuberculosis and venereal disease control activities. On the other hand, the variety of programs promoted in the United States, at least in the better developed public health jurisdictions, is not found in Europe. In the four countries visited, the public health agencies do little in health education, mental hygiene, industrial hygiene, and chronic disease control (cancer, heart disease, or diabetes detection); mass case-finding surveys of all kinds are not so common as here. The reason may be that these personal health services are regarded as within the scope of clinical medicine, already more or less available through health insurance. In the United States, there is much evidence that the broad

interests of public health agencies in new fields—especially the chronic diseases—are partly a result of pressures for organized medical care programs not being adequately met in other ways.

The thoroughness of much public health activity in Europe is due in part to a stronger “police power” tradition than characterizes American health work. Nontreatment of venereal disease for example, is usually a crime, punishable by imprisonment. In England, school health services are provided for every school child in the land, since every school authority is compelled by national law to provide such services. Mandatory legislation of this type, even on a state-wide basis, is unknown in the United States. Because of the same legal tradition, the whole field of housing sanitation is far better developed as a public health function in Europe. Health departments in Great Britain, Sweden, and France inspect rented dwellings and can prosecute violations. On the other hand, public sanitation functions, like supervision of the water supply or the pasteurization of milk, are not so well developed on the Continent as in America. In France, one cannot be sure whether the water and milk supplies get inadequate protection because of the engineering costs involved or because of the terrific importance of a third beverage; even Coca-Cola was sacrificed for the welfare of the wine industry.

The administration of public health in France is strangely divided between two official agencies in each community: the Public Office of Social Hygiene and the Office of Public Health. The former agency conducts personal health service programs like venereal disease control, tuberculosis control, and maternal and child health work. The latter handles environmental sanitation, statistics, laboratory services, quarantine, and medico-legal work. At the Ministry level these are united, but in the local communities they are separate because of their historic origins. While this may seem peculiar to Americans, it is perhaps no more bizarre than the dispersion of administrative responsibility for health services among scores of governmental

and voluntary agencies in this country. In one West Virginia county the writer found 155 separate agencies, governmental and voluntary, to be involved in organized health services for either the prevention or treatment of disease. In Europe, the frequent practice of governmental subsidy and partial supervision of voluntary agencies—for example in tuberculosis and child health work—assures teamwork between private and public action.

PROFESSIONAL EDUCATION

Medical education is quite different in Europe from that in the United States. To understand the differences, one should trace the doctor's training from its childhood beginnings in the primary grades, for the content of primary and secondary schooling in Europe differs appreciably from that in America. While it varies in different countries, it is generally believed that by the completion of high school (12th school year), the European student has had training equivalent to the first two years of college in this country. Then, following secondary school, medicine usually requires one continuous program for six or seven years, rather than four years of college followed by four years of medical school. One of the striking differences within this system is that clinical work usually starts earlier; almost from the beginning the student sees patients. This may have the effect of integrating theory and practice more successfully than is often the case here. The European student may see his patient more "as a whole" than does the American student who meets his patient only after years of pure theory in the lecture hall and laboratory, and then quite naturally views him merely as an example of some pathological process.

With this approach in medical education, it is not surprising that the role of the teaching hospitals is relatively even greater than here. Most of the teaching throughout the six years is done at the hospitals and one University, like the University of London or the University of Paris, may contain several medical schools, each associated with a separate hospital. As a result of

his training, the English, French, Swedish, or Swiss physician may be more empirical in his practice, less well grounded in solid scientific theory. In France, this is complicated further by the fact that a majority of graduates do not have a period of post-graduate hospital training, equivalent to our internships and residencies.

Despite the great development of social services in Europe, the teaching of public health and preventive medicine seems to be less well developed than even in American medical schools. Little formal instruction is given in public health, which is regarded chiefly as a post-graduate subject to be studied in one of the schools of hygiene. It may be that the physician is expected to learn public health medicine from experience, as soon as he is in practice. Likewise little or no instruction is given to the undergraduate in the theory or operation of health insurance programs, perhaps because this represents elementary "civics" taught in secondary schools and experienced in everyday life. The teaching of "social medicine" consists, mainly of instruction on the effects of poverty, poor housing, heredity, malnutrition, etc. in the epidemiology of specific diseases, rather than discussion of organized programs of medical care. In the graduate schools of hygiene or public health, American observers are surprised to find almost exclusively physicians, and virtually none of the nurses, engineers, health educators, statisticians, and others who constitute a major portion of the enrollment in American schools of public health.

Throughout Europe, and especially in Great Britain, the midwife has a respectable and integral place in medical service. A large portion of deliveries in the home have long been performed by women trained in midwifery and doing a good quality of work. Physicians are called for difficult cases, but the availability of the midwife for the normal obstetrical case has helped to compensate for Europe's relative shortage of physicians. With increasing hospitalization of maternity cases, the role of the midwife has waned. The arm of the physician is extended also by nurses, who perform a wider range of medical tasks in

the hospital and in the patient's home than is conventionally permitted in the United States. In Sweden, it is commonplace for nurses to discuss the management of cases with physicians, and Swedish nurses visiting American hospitals are surprised at the subordinate role of their American counterparts. In France, the emphasis on psychological and sociological viewpoints in the training of the nurse is heartening. Nurses going into public health work receive training equivalent to one year of social work and all French social workers receive the equivalent of one year's training in nursing.

THE QUALITY OF MEDICAL SERVICE IN EUROPE

The previous discussion, while far from an adequate account of health service organization in Great Britain, Sweden, Switzerland, and France, may help to provide a background for evaluation of European medical care compared with American. It is very often said that the quality of medicine deteriorates under governmental medical care programs—whether insurance or tax supported—and the evidence often offered is that “medicine in Europe has gone downhill.” This is a serious and damaging charge, but it is difficult to find corroboration of it among responsible bodies of European physicians. Individual European practitioners have broadcast unfavorable descriptions of perfunctory work done in the office of a doctor working under compulsory insurance legislation, but the professional societies, the academies, and the teaching centers do not confirm these accounts as a fair picture of general conditions.

While European medicine, on the average, has probably not deteriorated, it cannot be denied that it has failed to advance as rapidly as has American medicine. Europe, once the world center of medical science, has given way to the United States; American medicine, once weak, has in many respects come to surpass European medicine in technical excellence. The meaning of such comparisons, however, is deceptive. How much are these evaluations influenced by the quality of work done in the great teaching centers of the two continents and how much by

a sober evaluation of the level and scope of service available to the average citizen, rich, poor and in-between?

Much of America's technical superiority is due to our research programs. We are doing more research in almost all fields of medicine and public health than is any European country. Research costs money and we have more to spend. Great fortunes have been accumulated in the United States, yielding large philanthropic research endowments; industrial profits have made possible huge research programs under commercial auspices; government has increasingly subsidized research with tax funds. We have not been impoverished by the ravages of two World Wars. Yet we must be humble when we realize that even in recent years—let alone in past decades—some of the most important discoveries in medicine and public health have come from Europe: sulfanilamide from Germany, penicillin from England, and DDT from Switzerland.

If we attempt to focus, nevertheless, on the quality of medical service available to the average European, what can be said? There are undoubtedly many real problems; most of them relate to the conditions of general office practice, rather than hospital service. The insurance programs have enabled large numbers of people to have access to a doctor's office, but what happens to them when they enter the door? Keeping always in mind that a smaller proportion of Americans enter the doctor's office at all, those that do are likely to receive a better medical examination than does the average European. X-ray and laboratory work is less likely to be done for the European. Most, though not all, doctors are pressed for time. A quick prescription may be handed out in order to make room for the next patient. The doctor may lack interest in keeping informed on the latest scientific developments and may send his patient off to the hospital if a problem of the slightest complexity arises.

These criticisms of European medicine are frequently made by American observers. The same applies, however, to much general medical practice in the United States, especially for the 60,000,000 people living in rural areas and for the millions more

living in the crowded slums of our big cities. These problems are substantially the result of a high demand for service relative to the medical manpower available. Whenever the effective demand for service exceeds the supply of medical time, perfunctory care may result. The situation is complicated further by the sharp separation between the office and hospital practice of medicine. But are these problems a result of the insurance and public medical care programs in Europe?

SHORTAGE OF MEDICAL PERSONNEL

To gain an understanding of the qualitative problems of European medicine, it is necessary to view it against its total economic and historical setting. Why is there a relatively insufficient supply of doctors in Europe? The supply of doctors in a nation basically is economically determined. A nation can support only a certain number of physicians with the money it has to spend on physician's care, relative to other needs of daily living. If the number of doctors is increased beyond the economic capacity to support them, doctors will not survive and men and women will not undertake the study of medicine. China and India can only support one doctor to 50,000 people or more; France about one to 2,000; England about one to 1,200; the United States about one to 750. Other important factors enter, like the adequacy of professional schools and limitations that may be placed on acceptance of candidates for training, but the most fundamental determinant of the supply of medical personnel in a nation is its national income and the share of it available for medical service.

The systems of health insurance, rather than decreasing the supply of doctors relative to population, have stimulated a steady increase in the relative supply since the 1880's, when the first governmental programs were enacted. In the United States, the relative supply of physicians has actually declined in the same period. Health insurance and public medical care programs have reserved larger shares of the national income for health services and made possible great expansion of the

supply of both doctors and hospital beds. At the same time, the reduction of economic barriers for the consumer has obviously increased the effective demand for medical service. The question then becomes: has the increase in the supply of personnel kept pace with the increased demand for service? Idealistically considered, the answer is probably "no." The difficulty is that the insurance systems have not spent enough money, for there are still not enough doctors. Expenditures within the insurance and tax-supported medical services have risen steadily—with the expanding demands for medical service and the increasing complexities of medical technology. But there is a limit to the expenditures a nation can support for medical care, just as there are limits to the reasonable expenditures of a nation for houses, bathrooms, or four-lane highways.

These rising costs of governmental medical care programs have, indeed, been attacked by American critics as evidence of the "extravagance" of compulsory health insurance. It is difficult to reconcile this viewpoint with the fact that greater expenditures make possible an expansion of personnel and facilities. The problems have been created not by the abundant expenditures of the programs, but by their frugality. Despite the rising expenditures, European economies still seem to put less money proportionately into medical care than does America. The total cost of the British National Health Service—even after the large increase in costs beyond the initial estimates—amounts to less than 4 per cent of Britain's national income, while expenditures in the United States are estimated at over 4 per cent of our income.

Fundamentally, the insurance and related programs have helped to ameliorate the difficulties in European medical service caused by economic facts, rather than having produced these difficulties. Striking evidence of this is the fact that the British, French, Swedish, and Swiss Medical Associations have not advocated the abolition of the insurance programs, but rather their expansion to cover larger proportions of the population and wider scopes of service. The British medical profession

remembers the "two-penny doctor" in the large cities before the first National Health Insurance Act of 1911 who, to make a scant living among his poverty-stricken clientele, had to charge ridiculously low fees. The insurance programs brought a better assured income for him, just as they did for doctors throughout Europe and just as Blue Cross plans in the United States, for example, have helped the hospitals financially. Not that physicians have been satisfied with the fees they receive under insurance programs. In France, today, there are bitter complaints about the government fee schedules and the British Medical Association has been battling hard for higher capitation payments to general practitioners. But these complaints are within a framework of acceptance of the total medical care program and they mean that more insurance is wanted, rather than less. To satisfy them would require adjustments in the remuneration of other classes of personnel or facilities (such as the dentists who have been earning disproportionately high incomes under the British program) or the reduction of other expenditures in the total economy to reserve more funds for medical care.

If elevation of fee payments would cause a greater aggregate national expenditure for medical care, it is obvious that increases in the over-all supply of physicians would do likewise, or else average physician's earnings would decline. The persistent question remains how large a sum a nation can reserve from its national income for medical expenses, in relation to housing, food, clothing, and other essentials? One may then ask: "Why institute programs of compulsory health insurance or public medical service if a nation cannot afford to support adequate numbers of personnel and facilities to meet the demands for service?"

The answer must be found in the general social facts about Europe epitomized in its age, smallness, poverty, and suffering. These conditions have given rise to a strong demand for social improvement. The attitude of the governments elected to power has become: *we may not have enough resources, but*

what we have will be more or less evenly divided among us. This has undoubtedly resulted in a situation—seen most sharply in England—in which a small percentage of persons of relatively high income cannot obtain as much medical service as they could when they paid for it privately, simply because the doctor has more demands on his time. But there can be no doubt that, under the governmental programs, the far larger number of persons who are of low or moderate income receive more medical care than they could possibly have afforded privately.

PATTERNS OF MEDICAL PRACTICE

Aside from the inadequacy of personnel, the relationship—or lack of it—between general medical practice and hospital services creates serious problems for the quality of European medicine. Is the isolation of the general practitioner, however, a consequence of the governmental insurance programs? The fact is that the independent development of hospitals, and specialist services within them, long antedates the insurance programs. It relates to the historic origin of hospitals as places for the sick poor. Sweden has operated public hospitals since about 1790 and Paris' Hotel Dieu or London's Guy's Hospital were established long before this. As both public and voluntary hospitals came to serve the great majority of the population at the expense of taxes or charity, the system of full-time salaried specialists attached to the institutions developed in the interests of both economy and efficiency. Even when the hospital specialists were not full-time, as in France, their services were seldom remunerated on a private fee basis. The opportunity for the average physician to use the hospital as an extension of private office practice, with private fees, was rare. (A separate system of "nursing homes," of small aggregate capacity, developed to serve this purpose for the small class of high income patients.) This economic foundation of the American doctor's "hospital connection" lacking, it is natural that general office practice should have become increasingly isolated from hospital medicine.

If anything, the European insurance programs have probably strengthened office practice by making private physicians accessible to patients who might formerly have gone to the free outpatient hospital clinics. Moreover, the ready access of the general practitioner's patients to hospital service is, after all, a tremendous help to both doctor and patient. It is conventional for the hospital to send the general practitioner a full report on his patient, helping to provide some continuity of care. Nevertheless, the stimulating professional influences of hospital affiliation are not available to most European physicians. This is an organizational challenge yet to be faced; the same problem, in reverse, is being faced in the United States, with general practitioners increasingly losing hospital connections which they once enjoyed.

Even within the limited supply of doctors in Europe, a better quality of service might be possible if certain organizational changes were made. Such changes, however, would make European medicine more socialized rather than less. Thus, while many physicians are over-worked and give perfunctory care, others are not working to capacity, exactly as under private practice in the United States. This is not necessarily a reflection of competence but may be related, as in America, to length of time in practice, location, social connections, "bedside manner," or professional competition. As long as free choice, private office practice is the rule, as it is throughout Western Europe, these disparities will probably continue. Only a completely salaried medical service could make full utilization of all available medical manpower, on a rational basis. Despite the acceptance of this pattern for most hospital service, it is generally opposed by the physicians for office practice.

It is proposed in England that the quality of general medical practice will be elevated by the eventual construction of health centers, in which groups of general practitioners will work together, aided by auxiliary personnel and diagnostic equipment. This is, of course, different from the American conception of group practice, involving a team of general physicians and num-

erous specialists. With specialism tied to the hospitals, it is natural that the American type of private medical group for ambulatory patients should be very rare in Europe. The British plan, nevertheless, would correct much of the unhealthy isolation and individualism of solo office practice; it would also promote closer organizational connection between general practitioners and hospitals, since health centers would be professionally related to hospitals in a regional scheme. For the present, the construction of health centers is delayed by the requirements of general public housing and military mobilization.

The quality of office medical practice might also be improved by fuller utilization of auxiliary personnel to conserve the doctor's time for essential duties. This could be most economically done in group medical clinics; in solo practice it would be feasible on a large scale only if larger aggregate payments were made to doctors to enable them to support auxiliary workers. In Great Britain, almost 50 per cent of patients coming to doctors' offices are not seeking direct medical service, but rather disability certifications, permits for certain rationed products, etc. These professional services are essential for other important programs, but their performance could be greatly expedited through a screening of cases by auxiliary health personnel. The same applies to the general record keeping and reports necessary to systematic medical service. It should be added that the volume of "paper work" in the British National Health Service, itself, is small. No reports to the government are required on diagnosis, treatment, fees, volume of service, or other details of medical care; only referrals for specialist service, prescriptions of drugs, disability certifications, and the like call for written forms, exactly as are required in the usual American practice. In Sweden, Switzerland, and France, where payments to physicians are on a fee-for-service basis, vouchers must be filled out for reimbursement—equivalent to private physicians' bills here—but even these tasks could be simplified by clerical assistance.

Systematic post-graduate education of physicians would be another entree to an elevation of the quality of service which

warrants further development in Europe. The use of standard drug formularies would be an additional device, consistent with practices in the finest medical centers. These and other measures, which might elevate the quality of service, would be steps toward greater rather than lesser organization of the European medical professions. Western Europe has more and more organized the financing of medical care by the population, without a commensurate organization of the pattern of providing services. In the hospitals, where the latter has been carried much farther, the quality of service is high and, except for the shortage of beds, the problems are few. Yet, it is significant that the organized medical professions in various nations have few complaints about the place of physicians in the hospitals. Salaried positions on hospital staffs are eagerly sought and there are far more candidates than openings. The complaints of European physicians relate almost entirely to the rates of remuneration for office practice and the heavy demands on the time of successful general practitioners, problems already discussed.

SOCIAL TRENDS

Today in Europe we are seeing great social movements. Consider the significance of the British income tax of 99 per cent on earnings over 5,000 pounds (\$14,000) per year; castles and estates everywhere are being converted to rest-homes and parks. Consider the French Social Security levies of 35 per cent on wages and salaries (29 per cent paid by the employer and 6 per cent by the worker), used mainly for an elaborate system of family allowances which yield, in effect, higher wages to persons with more dependents. Increasing classes of industry are being nationalized, prices are controlled, scarce goods are rationed equitably, social services of all types are being extended. Whether or not these changes will lead gradually to complete socialism, as the British Labor Party envisages, remains to be seen. Difficulties in international relations still complicate internal social policies. Nevertheless, democratizing social change is the order of the day; there is little talk

of war and much talk of constructive planning, such as that which characterized the American scene at the height of the New Deal in the 1930's.

The organization of health services is only one part of this movement, but it is a very important part because medical care is so intimate a need of everyone. In health services, the social movement takes the form of spreading the available services to all people in such a way that, while the supply of personnel and facilities is limited, the criterion for priority becomes not the extent of purchasing power but the extent of medical need. The transition is obviously difficult for the doctor, compelling him often to work much harder for only a slight increase in financial reward. But the people everywhere have demanded it. It will be recalled that one of the few things in the Labor Party program in Great Britain not attacked by the Conservative Party was the National Health Service. The same multi-partisan unity toward health service organization has characterized the other nations of Europe.

Ultimate evaluation of the impact of the European medical care programs on the quality of service depends on how "quality" is defined. What happens to the quality of service for 1,000 persons when all of them are provided some essential care, compared with a situation in which 100 receive a "luxury" volume of care, 400 receive a moderate volume of care and 500 receive hardly any at all? Considering all 1,000 persons, does the quality of service go down or up; can quality be separated from quantity? This is perhaps a somewhat oversimplified formulation, but it symbolizes the nature of the developments in European medicine and the difference between European and American conditions.

There can be no doubt that Great Britain, Sweden, Switzerland, and France are proceeding toward a time when medical services will be a right rather than a privilege for everyone. There remain serious problems complicating the attainment of this goal, but at rock bottom these problems are mainly economic and historical. It is the economic difficulties, expressed

principally in shortages of personnel, and the historical development of European hospitals that have caused the medical problems, and not the systems of insurance or public support of medical services. The latter have been corrective measures designed to adjust to the underlying social situation, and without them the professional problems would be more serious. The ultimate attainment of Europe's health service goals will depend on the achievement of world peace and the improvement of general economic conditions.