A similar study by the authors using the 1950 Census residence data is now reported under way and it is to be hoped that means will be found to resolve some of the problems with which the present study faces us. While it may not be possible to analyze the social class rates of migrants and nonmigrants it should at least be possible to give us the rates for migrants from different states. Also, it should be possible to divide up more usefully the rag-bag of "other psychoses" so that one may gauge to some extent how far the migrant suffers from more transitory or more chronic conditions; perhaps one might even get something on length-of-stay or outcome. But before one asks for more and more details it might be as well for us to reconsider the validity or usefulness of the concepts on which such questions are based.

H. B. M. MURPHY

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HEALTH AND MEDICAL CARE IN NEW YORK CITY[1]

FOR almost thirty years, the only comprehensive data available on the costs and other financial aspects of provision of medical care for families in the United States, have been in the reports of the Committee on the Costs of Medical Care, 1928–1931. Unfortunately, a great depression, a recovery, a war or two, and other social and economic upheavals have lessened the value of the 1931 data of the Committee on the Costs of Medical Care in understanding present needs in medical care and in planning adequate service programs. It is true that other studies have contributed to the sum of knowledge of how, where, for what, of whom, and even why the North American family purchased health services. It is also true, however, that most of these other studies have been limited in approach, circumscribed in scope, and, occasionally, selected for

[1] Report of the Committee for the Special Research Project in the Health Insurance Plan of Greater New York: HEALTH AND MEDICAL CARE IN NEW YORK CITY, published for the Commonwealth Fund. Cambridge, Massachusetts, Harvard University Press, 1957, ix+275 pages, $7.50.

their apparent ability to bolster one or another side of controversial issues. This is not to say that the absence of valid and extensive recent data prevented endless theoretical discussions, but it made them productive often of more heat and less light.

Now, within the span of a few years, three new studies, one under way and two completed, will go far toward closing the gaps in our knowledge of health services and their cost. First, the National Health Survey of the Federal government will yield a wealth of information on health and disease in persons in the United States. Second, Anderson and Feldman's report for the Health Information Foundation[2] has provided a comprehensive nationwide picture of medical costs actually incurred by families and the extent to which health insurance meets these costs, with a great deal of data hitherto lacking. Third, extensive in depth and giving essential detail rather than broad geographic coverage, the report of the Committee for the Special Research Project in the Health Insurance Plan of Greater New York, HEALTH AND MEDICAL CARE IN NEW YORK CITY,[3] will, when joined to the others, constitute one of the significant sociological indexes of the mid-century.

Parran, in his foreword to the HIP report, says, "the present study raises almost as many questions as it answers." I would go further, and say that it raises many more questions than it answers, but what good study does not?

Most people are by now well aware that the Health Insurance Plan of Greater New York, started in 1947, was designed "to be a practical demonstration of the values to families with moderate incomes of comprehensive prepaid medical care rendered by group practice units called medical centers." Payment for service is customarily met by joint contributions from employer and employee. The largest single employer contracting with the Plan was and is the City of New York. The group practice units are medical partnerships compensated by capitation payments for enrollment, not fees for medical services. Hospital services are obtained by the requirement that all sub-

[2] Anderson, Odin W., Ph.D., and Feldman, Jacob J.: NATIONAL FAMILY SURVEY OF MEDICAL COSTS AND VOLUNTARY HEALTH INSURANCE, A NATIONWIDE SURVEY, for the Health Information Foundation. New York, N. Y., McGraw-Hill Book Co., 1956, 251 pages, $6.50.

[3] *See* footnote 1.

scribers must carry hospital insurance. Medical services are comprehensive, and include home, office, and hospital services by general practitioners and specialists, plus auxiliary services, with relatively few exclusions. Accent is placed on preventive services, as well as care for illness and injury, and great efforts are made to safeguard the high quality of service.

Many questions faced the organizers of the Plan at its inception for which data for answers were meager or lacking, not only for the New York City operation, but for the country. These were practical questions of organization, acceptance by professional and lay persons and groups, and utilization of services, as well as questions of possible abuse of the extensive benefits included in the contract, use of preventive services, and in general, the effect of the plan on the health and health habits of the subscribers. Though the Plan built mechanisms for research into its administrative machinery, a truly searching inquiry of the need and demand for services called for a more substantial field study than regular statistical reporting could provide. In addition, in statistical terms very little was known about the details of the private practice of medicine in New York City. Hence the present study was devised to seek these answers. It was designed under the auspices of a distinguished planning committee chaired by Selwyn D. Collins, Ph.D., and an equally distinguished steering committee under the chairmanship of Lowell J. Reed, Ph.D., supported by funds from the Rockefeller Foundation and the Commonwealth Fund.

The Household Survey portion of the project, carried out in the Spring of 1952, resulted in the collection of data on 3,235 households with one or more persons enrolled in HIP, and 4,190 New York City households not in HIP. The HIP households, 2.7 per cent of HIP membership, had 10,981 persons, of whom 8,040 had HIP coverage, while the New York City households, comprising 0.2 per cent of the City's population, had 13,558 persons. The sample design and the interviewing process are discussed fully in the appendix of the report. An interesting innovation introduced into this study and used in some others, like the California Morbidity Research Project, was the inclusion in the interview of a battery of questions approaching the matter of illness in the family from several points of view in

order to probe the memory of the respondent, as it is well known that ordinarily morbidity data are substantially under-reported in most surveys. For example, in the Hunterdon studies of rural health,[4] the families' reports of illnesses agreed closely with the diagnoses of their family physicians when the latter were made aware of the interview content, but were very considerably under-reported when compared to the findings of examinations performed by the team of outside clinical specialists doing part of the study, particularly for certain conditions like diabetes and cancer.

The schedule of questions asked about the illness status of each person in the household on the day previous to the interview, about all illnesses that had occurred within an eight-week period previous to the interview, and about illnesses in 1951 that required hospitalization over at least one night, or a period of seven days at home in bed. It also inquired about defects, minor chronic conditions, some physical problems not ordinarily thought of as "illness" (e.g. sterility, obesity, menopause), check-ups and routine health examinations, certain specific symptoms, and a separate question on a set of nine chronic conditions. A columnar form was used, with a separate column for each member of the household, and in certain cases the interviewer prepared a special supplementary schedule when an illness or disability was reported. While the frequency of illnesses, injuries, and other medical conditions found in this survey cannot be compared exactly with the findings in other surveys, the frequency appears to be greater than the amount found in general illness surveys conducted prior to 1950, so the general objective of securing more adequate morbidity data was considered at least partially successful.

The Household Survey had several specific objectives. First, it was designed to examine the extent of the New York City population coverage by insurance for hospitalization and medical care, and to compare the demographic and social character-

[4] (a) Trussell, Ray, M.D., Elinson, Jack, Ph.D., and Levin, Morton, M.D.: Comparison of Various Methods of Estimating the Prevalence of Chronic Disease in a Community. The Hunterdon County Study. *American Journal of Public Health,* February, 1956, 46, pp. 173–182; (b) Elinson, Jack, Ph.D., and Trussell, Ray, M.D.: Some Factors Relating to the Degree of Correspondence for Diagnostic Information as Obtained by Household Interviews and Clinical Examinations. *American Journal of Public Health,* March, 1957, 47, pp. 311–321.

istics of the groups being studied. It was known in advance that there were some differences between the HIP enrolled population and the City population. These population groups are compared early in the report for a number of demographic characteristics, and thereafter demographically comparable groups were used wherever possible in the examination of the data. Second, the Household Survey enabled comparison of the groups with respect to their medical needs; medical care given, including preventive services; unattended illnesses; some broad indexes of quality of care received; extent to which medical care is sought; and some estimates of total morbidity and needed health services for New York City's population. The designers of the study hope the Survey has made a contribution to improved methodology in investigations in these fields of interest.

Studying the insurance status of those known in advance to be HIP enrollees, it is interesting to find that 8.9 per cent of enrollees did not report (or presumably know?) they actually were enrolled in HIP, and 3.4 per cent actually reported they had no medical care insurance! These are significant figures, especially in light of the fact that HIP enrollees are probably subject to more educational and informational material than members of any other medical care insurance plan.

In the New York City group, 54.6 per cent of persons in the sample reported having some type of medical care insurance. The accuracy of this figure is questionable in view of the responses of known HIP enrollees just described. The bulletin of the Health Information Foundation, discussing the findings of the NATIONAL FAMILY SURVEY OF MEDICAL COSTS AND VOLUNTARY HEALTH INSURANCE, for the period of June and July 1953, reported that 57 per cent of the families studied nationwide, but 70 per cent of urban families had "some coverage." The HIP Research Committee accepts the comparison with these figures as indicating that the returns from the New York City survey appear to be reasonably accurate, but others might question this conclusion.

The survey presents further data on various demographic characteristics of each sample group, and comparisons are related to insurance status of the household members.

One of the significant comparisons in the study of data related to physician contacts by HIP members and members of other New York City groups is on the percentage of persons in each group who saw a doctor, by number of times the doctor was seen. More of the former than of the latter saw a doctor in 1951. However, HIP enrollees, other members of their families not covered, and the general population had generally about the same experience in terms of the number of times they saw a doctor during the year. This should answer many fears and questions on "over-utilization" of medical service when economic barriers to physician visits are removed.

It is claimed that persons served by group practice units do not establish a "patient-family physician" relationship because complete free choice of physicians is not available. In this report, the reverse appeared to prevail, since 77.9 per cent of persons in the New York City sample were in families who claimed to have a family physician, while 88.7 per cent of the HIP enrollees were in families who claimed to have a family doctor. (The panel method in HIP permits the selection of a general practitioner who continues with the family as a family physician.)

As might have been expected, HIP families tended to use pediatricians for the care of children under age six more than did families in the City sample—63.3 per cent compared with 42.4 per cent.

A large mass of material is presented on the medical conditions reported, characteristics of the persons with medical conditions, the medical care they sought and received, frequency of specific illnesses and degree of disability resulting, for the groups studied. This information will undoubtedly be of great value, since much of it was hitherto unknown, especially with the degree of accuracy provided in this study. The data and their implications are discussed in detail, including any light thrown on the possible effect of a prepaid medical care plan on the health of its enrollees. For example, the HIP enrollees reported a higher frequency of chronic illness than members of the general City population sample among persons in the labor force, during the eight-week period preceding the Household Survey. It is suggested that HIP enrollees can more readily

see a doctor and thus can control illness more easily and remain in the labor force. Further, since a large proportion of HIP enrollees are city employees enjoying liberal sick-leave privileges, their illness does not necessarily remove them from the labor force. Neither of these hypotheses can be supported or rejected from the data available. Many of such factors discussed point up the need for further and deeper investigation for additional significance.

The data on hospital experiences obtained by the Survey need cautious interpretations, and there is discussion in the report of the factors relating to reliability of the survey findings in this field. Comparison of hospitalization experience developed the unexpected finding of a hospitalization rate of 7.5 per 1,000 persons for those without reported hospitalization coverage, compared with 6.2 per 1,000 persons for those with such insurance. Most published data from other studies indicate higher utilization by insured persons. To check this unusual finding, Blue Cross data for New York City were obtained. These yielded an annual utilization rate of 11.4 persons per 1,000 covered, or somewhat higher than the HIP survey count. Nothing in the latter data suggested that those not covered should have a rate higher than the insured group. The report speculates that the difference may be due to such factors as poor knowledge or recall on the part of the respondents, faulty recording by enumerators, or possibly the peculiarity of the New York City population. In view of the unanswered questions, the report wisely does not later classify data on hospitalization by insurance status, except in discussion of length of hospital stay.

In view of the observed and unexpected findings of reports of hospitalized illness, usually thought to be more completely reported than other illness, it is interesting to speculate on the reporting of non-hospitalized illness as a reflection of the actual occurrence of such illness.

Although dental services are not included among the benefits for enrollees under HIP contracts, a comparison was made of the dental care received by the groups under scrutiny. More persons in the HIP population were receiving dental care at the time of the survey than persons in the general population.

There were few other significant differences, but much general information is presented on dental services, as on medical services.

Regarding preventive services, there were some implications that HIP enrollees were receiving more health care and guidance than their counterparts in the general population, but the differences brought out in this survey were not great. The report acknowledges the difficulty of determining data on personal preventive services.

In conclusion, this fascinating and provocative report will provide factual data for discussion and questions for deeper investigation for a long time to come.

NATHANIEL H. COOPER, M.D.

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POPULATION REDISTRIBUTION AND ECONOMIC GROWTH[1]

WHEN a prominent economist with a special interest in economic development and an equally well-known sociologist with a special interest in migration team up to direct a study of the *interrelations* of population redistribution and economic growth, the results are rather bound to be good. This is particularly true when the principals in the case are Simon Kuznets and Dorothy S. Thomas and when they have the help of able young assistants.

The results of this project are being published in two volumes, under the general title POPULATION REDISTRIBUTION AND ECONOMIC GROWTH, UNITED STATES, 1870–1950. The first volume appeared in 1957 and bears the subtitle METHODOLOGICAL CONSIDERATIONS AND REFERENCE TABLES. It contains an Introduction by Kuznets and Thomas, and four sections prepared by the contributing authors.

[1] POPULATION REDISTRIBUTION AND ECONOMIC GROWTH, UNITED STATES, 1870–1950. Vol. 1. METHODOLOGICAL CONSIDERATIONS AND REFERENCE TABLES, by Everett S. Lee, Ann Ratner Miller and Carol P. Brainerd, and Richard A. Easterlin. Prepared under the direction of Simon Kuznets and Dorothy Swaine Thomas. Philadelphia, The American Philosophical Society, 1957, xviii + 760 pp., $5.00.