tion from his patients. Above all he is governed by a committee of men who know nothing about Medical Economics, Medicine, and Pharmacy. All that this committee is interested in is the economical side of the society, thereby disregarding many essentials that would benefit the sick and assist the physician and the pharmacist.

If these people would have to go to the doctor and pay him for the consultation, the patients would be much better taken care of. They would appreciate the doctor more and would have more respect for him. The doctors would also be better off, both financially and professionally. No doctor, however good he may be, can under proper circumstances take care of thirty to sixty patients in an hour or two; even if three-fourths of the people are not really sick. The proof is that many times when something serious happens to them they seek outside medical aid.

PHARMACY'S POSITION UNDER REGULATED COMMUNITY MEDICINE.*

BY DR. GEORG URDANG.[1]

In the April issue of the JOURNAL (Vol. 26, No. 4) a discourse about "Pharmacy's Position Under Regulated Community Medicine" was published which had been delivered by Mr. P. J. Callaghan at the A. PH. A. meeting held in Dallas in 1936 (Section on Education and Legislation).

The author says at the end of his explanation:

"This subject is of tremendous importance to the pharmacist of the United States."

Everybody who is acquainted with the conditions of European Health Insurance Plans, especially with the pharmaceutical problems involved, will confirm this statement. The European experiences demonstrate with the highest clearness that socialized medicine, its form and development, are questions of highest importance for the state of Pharmacy and for the pharmaceutical profession as a whole.

It seems necessary to be informed as well as possible of all experiences made on this subject in other countries as these experiences of other peoples are the possibilities of your future.

First of all, I would express the opinion that Mr. Callaghan's discussion of European Health Insurance Plans is excellent and well worth our study and consideration. Nevertheless it is my humble judgment that some of his conclusions are based upon a picture of the European situation that is not absolutely in harmony with existing facts as they appear to me.

The situation is as follows:

The first modern Social Security Legislation was created in Germany. The intention of this legislation, introduced by the imperial message of November 17, 1881, was to counteract the increasing power of socialism by a well-planned official social welfare program.

---

* Presented at Section on Practical Pharmacy and Dispensing, A. PH. A., New York meeting, 1937.

[1] Former Editor of the *Pharmazeutischen Zeitung*, Berlin, Germany.

It is not my task to prove whether the above program actually fulfilled its purpose. Nevertheless the fact must be noticed that the leaders of socialism in Germany gained very quickly final influence in State Health Insurance or socialized medicine. After a relatively short space of time, most officials of the largest and most important groups of German Health Insurance Bodies ("Ortskrankenkassen") were socialists. Naturally they tried to put into practical effect their political ideas in these positions. Herein lies the origin of the sometimes incomplete and inadequate examination and treatment, both medical and pharmaceutical, of State Medicine, which is frequently lamented.

Mr. Callaghan's remark that "the quality of medical care rendered under such systems is far below the average quality usually given in this country" is only conditionally correct. Such a situation was always more a danger and a possibility rather than a fact. It is the exception rather than the rule, "that" as Mr. Callaghan says "in Germany, when a person has a serious ailment he will go to an outside physician for treatment."

Naturally in all countries with State Health Insurance which includes the necessary medicine required by the insured patient, the physician must be mindful of economy. In my Compendium of the History of German Pharmacy ("Grundriss der Geschichte der Deutschen Pharmacie"), published in 1935 in collaboration with Dr. Adlung, I have described in detail the development of the relationships between the State Health Insurance and the pharmacists in Germany. There I have listed all the restrictions imposed upon both, physicians and pharmacists, in the pharmaceutical treatment. Many restrictions have been introduced, tried or at least proposed. Such restrictions or injuries against the private pharmacist are:

1. The doctor's obligation to prescribe only such medicines or substances as found in the official lists, called in Germany "Arzneiverordnungsbücher."

2. The delivery of medicines by the local Health Insurance Bodies themselves, which for these medicines partly excludes the pharmacist.

3. The establishment by local Health Insurance Bodies of their own pharmacies, or the establishment of a partnership between a local Health Insurance Body with one private pharmacy.

4. The manufacture or wholesale distribution of remedies and surgical supplies by the local Health Insurance Bodies or their associations.

5. Attention by physicians to legal requirements to economize in prescribing medicines and supplies.

6. The liability of the physician for all remedy costs exceeding a fixed amount within a fixed time for every insured patient.

7. The obligation of the insured patient to pay a fixed part of the costs of every prescription in order to interest the insured patient in low remedy costs.

In connection with these seven points I wish to say further:

1. The lists of medicines or substances allowed to be prescribed for insured patients by the physicians with restrictions, were introduced only in Germany and have been removed in the last years.

2. The delivery of medicines by the local Health Insurance Bodies was introduced principally in Germany and in Austria. In both countries this has been abandoned in recent years. In Germany this delivery has always been confined

to the remedies which the German law permits every person to sell, even non-pharmacists and outside pharmacies ("Freigegebene Arzneimittel").

3. Pharmacies owned by local Health Insurance Bodies exist in Poland, in some Baltic countries, and in some parts (cantons) of Switzerland. In most European countries the establishment of such pharmacies is forbidden. The partnership between local Health Insurance Bodies with private pharmacies is generally illegal. From the public protest demonstration of the Belgian Pharmaceutical Association we learn that such illegal partnership exists quite extensively in Belgium. The pretended private owner of the pharmacy in question is often in reality an employee of the local Health Insurance Body. Similar conditions exist in Switzerland.

4. The establishment of factories for the preparation of remedies and the establishment of organizations for the wholesale distribution of medicines and supplies by Health Insurance Bodies has been tried in Germany and in Austria. In Germany after long legal struggle between the pharmacists and the Health Insurance Bodies these were declared illegal by the Courts. In Austria the situation is not fully clear. During the socialistic government an official institution was created in order to regulate the prices of medicine used for insured patients, the so-called "Heilmittelstelle." This institution acts as manufacturer and as wholesaler. Now its functions are being restricted and it is now quasi-public.

Since the principal axiom of socialism is the complete elimination of private enterprise, then it is evident that the idea of socialism is realized when a Health Insurance Body does manufacture and distribute remedies and supplies.

5. The need of attention by the physician to the legal requirement that he economize in prescribing exists in many countries.

6 and 7. The liability of physicians for all remedy costs exceeding a fixed amount within a fixed time for every insured patient and the obligation of the insured patient to take part in the remedy costs are legal in Germany.

The observations made above are valid as facts or possibilities for all European countries with State Health Insurance, except England. In England the physician and pharmacist are paid fixed sums, the latter 3 pence for a simple medicine and 5 pence for a compounded one, in addition to the cost of the ingredients.

Undoubtedly, many important and some partly important restrictions do exist for medical and pharmaceutical care in European Health Insurance. Some proposed restrictions are a dangerous possibility for the future. It is a curious fact that among the actual restrictions referred to we do not find the one mentioned by Dr. Callaghan, which is that remedies are delivered by the physician.

On the contrary the functions of the physician and the pharmacist are in the European Health Insurance Plan really separated. Therefore here is given a very important chance for the pharmacists in countries without such general separation.

As an inquiry organized by the Pharmaceutical Association of Switzerland in 1935 has shown, in Europe full liberty of delivery of medicine by the physicians existed at that time only in some Swiss cantons and in England.

In England the introduction of National Health Insurance has resulted in breaking down the former absolute liberty of the physician to deliver medicines to all his patients. Under the new English plan the physician is not allowed to deliver

medicines to insured patients. This delivery is permitted only to the pharmacist, and therefore the pharmacist is gaining ground.

The reason for this separation is evident and has the same validity in all countries of the world. The purpose is to avoid a conflict between the physician's duty and his profit. The physician shall be interested exclusively in the treatment of the insured patient and by no means in the profit for the medicine.

In the United States the physicians have the liberty of delivery of medicine as their English colleagues formerly had. It may be possible that the introduction of the Health Insurance Plan in the U. S. A. will have the same effect it had in England. This would be to the benefit of American Pharmacy as a profession.

The proper function of the pharmacist, as we all know, is to manufacture and distribute medicines and supplies to the people. On the continent the pharmacist accustomed to be regulated by strong laws, is now gaining by degrees more liberty, whereas in the United States and in England the reverse is true. Should it not be possible that all of them learn from each other what to do?

The introduction of Health Insurance Plans may be as well the ascent as the descent of professional pharmacy in the United States. What it will be depends entirely on the activity and intelligent interest of the American pharmacists, on their professional integrity and, last but not least, upon their profound recognition of all possibilities included and implied in this movement.

HOSPITAL PHARMACY IN THE COLLEGE CURRICULUM.*

BY MORRIS DAUER.[1]

In recent years pharmaceutical educators have made progressive strides toward the elevation of Pharmacy by means of a college curriculum which will adequately equip the graduate to meet the rigid demands made upon him by any branch or speciality in Pharmacy. They do not, however, give the consideration to that very important phase of pharmaceutical practice denoted as Hospital Pharmacy, which plays such a vital rôle in the maintenance of the physical well-being of the American people.

A careful scrutiny of the bulletins issued by the various colleges and schools of pharmacy reveals that with the exception of a very small number, no courses in Hospital Pharmacy are offered. As a result of this omission the graduate in pharmacy, when seeking a career in Hospital Pharmacy, finds himself sadly embarrassed and greatly handicapped because, although he possesses the basic and fundamental knowledge of Pharmacy in theory and practice, he finds himself unable to cope with the Hospital Pharmacy problems.

We must concede that Hospital Pharmacy is a highly specialized field which should be limited to men and women who manifest adaptability in this phase of Pharmacy. In the writer's opinion, based on many years of experience in Hospital Pharmacy, which were preceded by several years of retail pharmacy practice, the usefulness of a graduate who has not received training in Hospital Pharmacy is limited.

* Presented before the Sub-Section on Hospital Pharmacy, A. Ph. A., New York meeting, 1937.

[1] Chief Pharmacist, Kings County Hospital, New York City.