"Planning and Spontaneity in the Development of The Swedish Health System"

By

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THE SPEAKER

DR. ARTHUR GEORG WILLIAM ENGEL of Stockholm, Sweden's senior authority on health care, was Director-General and Chief of the National Board of Health of Sweden from 1952 to 1967. He was born in 1900, and received his medical education and training at the Carolinska Institute and the Department of Internal Medicine of the Serafimer Hospital, Stockholm. From 1934 to 1952 he headed the medical departments of central hospitals at Boden and Falun, and was medical director of Falun. He is President of the Swedish Hospital Association, a position he has held since 1954. Among his many other honors and responsibilities, he served as his country's delegate to the World Health Organization Assembly from 1953 to 1967; as Vice President of the Assembly, and a member of WHO's Executive Board; and as consultant to WHO and to the Secretary-General of the United Nations. He is chairman or member of several institutions and royal commissions on medical research and problems of health administration, and is the author of about 120 papers on internal medicine and public health. Dr. Engel sees health and welfare activity in Sweden as "deeply rooted in the humanism of the Swedish society." He will discuss the Swedish plan which effectively brings medical specialties into harmony with the health needs of the population.

THE SERIES

THE LECTURE SERIES was established in the name of Dr. Michael M. Davis, medical care pioneer, by his friends and admirers. Dr. Davis opened the series in 1963 with an address entitled "America Challenges Medicine." Each year a distinguished leader of medicine, the social sciences, hospital care, social welfare, government, labor or management is invited to address persons interested in the improvement of medical services. The intention is to stimulate free and open discussion and to furnish a forum in which medical care programs may be proposed, examined, and presented for public consideration.

THE OCCASION

DR. ENGEL delivered this talk at Billings Hospital, the University of Chicago, on May 9, 1968.

Early History

Until the Reformation at the beginning of the sixteenth century the Catholic church, local communes and even the state made the first endeavors to provide medical care, primarily for the poor population. Then followed a rather dark period lasting more than 200 years when very little was done and private action was minimal.

As late as the second half of the eighteenth century, the State founded the Serafimer Hospital in Stockholm and the Nosocomium Academiensis at Uppsala. Both were very small and, although modern for their time, poorly equipped. These were the teaching hospitals of the time. A third hospital of a similar type, the Sahlgrenska, was built at Gothenburg on the initiative of a private donor, whose name it still carries. A new period ensued, lasting more than a century; the state created hospitals located at the administrative centers of the about 15 Swedish counties of the period, and some larger cities established their own hospitals.

As early as 1846, Dr. C. J. Ekströmer, Director-General of the Hospital Services, later Director-General of the National Health Services, stated that the comparatively new county hospitals were functioning very well, and that their further successful development was best guaranteed if the counties were permitted to govern the local state hospitals with the absolute minimum of interference by the central state health authorities. "The State," he said, "should be responsible for the over-all planning only and fulfill an advisory and supervising function." More than a

century has passed since he uttered these wise words. As Ekströmer's late-day successor, I was happy to find that, during my 15 years of office, I have been in a position to confirm his experience over and over again. It is most remarkable that he had come to this conclusion long before local self-government was introduced.

From various private quarters funds have also been donated to hospitals and other institutions for medical and social care. The whole history of the Swedish hospitals up to this time is in fact a narrative of combined medical and social activities. After an era of scientific medical dominance in the field of public health and medical care—as we shall see—a turn towards a new integration has occurred in recent times. The circle is closed.

First Step of Regionalization

The year 1862 was a remarkable year in Swedish social history. The community self-government was now instituted by new laws for the local communes and, what is most important, on the basis of the historical state-governed counties a new regional self-governing body was created—the county council, elected by the citizens of the county and entitled to state subsidization and subsequently empowered with the right to impose taxes.

Among the duties of the county councils, as prescribed by the new legislation, health care—earlier exclusively a state concern—was included.

It is interesting to observe that the new law did not especially point out medical care among the many responsibilities that were placed with the county councils, and apparently did not foresee the coming dominating role of health care as a county function. The responsibility for

the care of the mentally ill and the district doctor organization remained, however, with the state for another hundred years. The full consequences of the philosophy of the 1862 legislation were first drawn in the 1960's when the county councils were successively made legally responsible for the whole sector of medical care in principle.

Nearly at once the administration of the hospital system became the most important task of the county council and has so remained. A main part of their budgets was from the beginning allocated to medical care. For a long time now the health share of this budget has been 80 to 85 per cent.

The Swedish hospital system entered immediately after the taking over by the county councils into a development phase that is still continuing and has made our hospitals known all over the world. As I see it, this happened primarily because the responsibility for the evolution was placed with a self-governing, locally elected body which knew the needs and understood the psychology of the population.

It was also most important that the county as a rule had the appropriate population size (250,000 on an average) to form a catchment area sufficient for a large qualified hospital.

The county council taxes have been rather popular—as far as taxes can be popular—among the population directly witnessing the useful application of the tax money and taking a real pride in having good hospitals.

The county councils early realized the importance of getting the best educated and trained clinicians attached to their hospitals, and were therefore anxious to provide them with good working facilities. They also guaranteed them

good incomes and very often excellent housing conditions. The basic salary was never high, but the doctors were permitted to use the outpatient departments of the hospital (always an essential part of a Swedish hospital) for their private practice—previously without charge, but nowadays regulated. It was rather a bright idea to make the doctors financially interested in treating as many patients as medically justifiable in the outpatient department, thus reducing the occupancy of hospital beds.

The county councils have also taken a liberal attitude towards clinical research inside the hospitals, being well aware of its importance for the standard of care, for the reputation of the hospital, and for recruitment of the medical staff. The junior medical profession realized, also, that here were offered excellent opportunities to practice and develop modern medicine, nearly comparable with those supplied at the university hospitals.

In the four largest cities (the county boroughs) hospital development has to some extent been hampered, as those cities have the same responsibility as a county council with regard to the hospital legislation, plus all the legal obligations of a local commune (municipality). Expenditure and investments for health purposes had therefore to compete with many other public requirements in getting appropriations from the single tax revenue here existing (an amalgamated local and county council taxation).

As earlier mentioned, the mental hospitals were administered by the state until the 1960's, and the state was in principle responsible for the care of the mentally ill. The just-mentioned cities, however, wanted to run the mental hospitals themselves inside their areas. This was

voluntarily agreed on, but the state had to pay a large contribution to the running costs because of its legal responsibility for mental care. Those mental hospitals very soon became better equipped and better staffed than the corresponding state-administered institutions. This experience was a stimulating factor when, in 1966, a Parliament decision at last was taken to transfer the mental hospitals to the counties and the county boroughs.

The first hospitals built by county councils were situated at the county capitals, and for some decades they remained, as a rule, the only hospitals inside the counties, replacing the old state hospitals, which had declined during the 1850's and 1860's. Step by step the different counties developed varying patterns of centralization and decentralization. Some were satisfied with one central hospital; others very soon established several district hospitals or distributed so-called cottage hospitals—sometimes many of them—over their territory. This could be justified in the sparsely populated areas of those counties where distances were great and communications badly developed.

The specialization inside clinical medicine was soon reflected in the organization of separate surgical and internal medical clinics, first at the teaching hospitals and the hospitals of the large cities. Around the end of the last century this specialization even reached the county level (the first was the clinical department of internal medicine at the central hospital at Falun in the county of Dalecarlia in 1897). Internal medicine, as a rule, was followed by X-ray, E.N.T., ophthalmology, obstetrics and gynecology. In the mid-twenties the hospital of the county capital became specialized in most counties. Not until in the

1950's did psychiatry and child psychiatry become represented with departments of their own.

The County Hospital System Gets a Firm Pattern

At the beginning of the 1930's a governmental commission was appointed to present a plan of the hospital organization for a county. The principle that every county should have a central specialized hospital and some local, district hospitals without specialization was now established. It was recommended as a guide to the counties, but has never—like any hospital plan—been mandatory. A period of an extraordinarily good development started, interrupted by the Second World War but soon renewed.

On January 1st, 1955, a compulsory health insurance scheme was introduced. It gave cash benefits during the period of working incapacity, free hospital care, reimbursement for (in general) three-quarters of the costs of other medical care, medicine at reduced prices or completely free of charge, and free choice of doctor. Most doctors were free to fix their fees, regardless of the insurance scale of reimbursable fees.

The Country-wide Regionalized Hospital Plan

Around the early 1950's new specialties like neurosurgery, thoracic surgery, plastic surgery, cardiac units, neurology, dermatology, radiotherapy, etc., already emerging at the teaching hospitals, seemed to be ready to be incorporated into the central hospitals of the counties. Organizational directives were necessary to prevent misplaced investments.

At that juncture I arranged a series of conferences with representatives of the new "supra-specialties," as I like to call them. It was soon clear that the existing administrative structure represented units too small for organizing those new hospital services. It was thought that roughly 1,000,000 inhabitants were necessary to constitute an appropriate catchment area for the majority of these specialties.

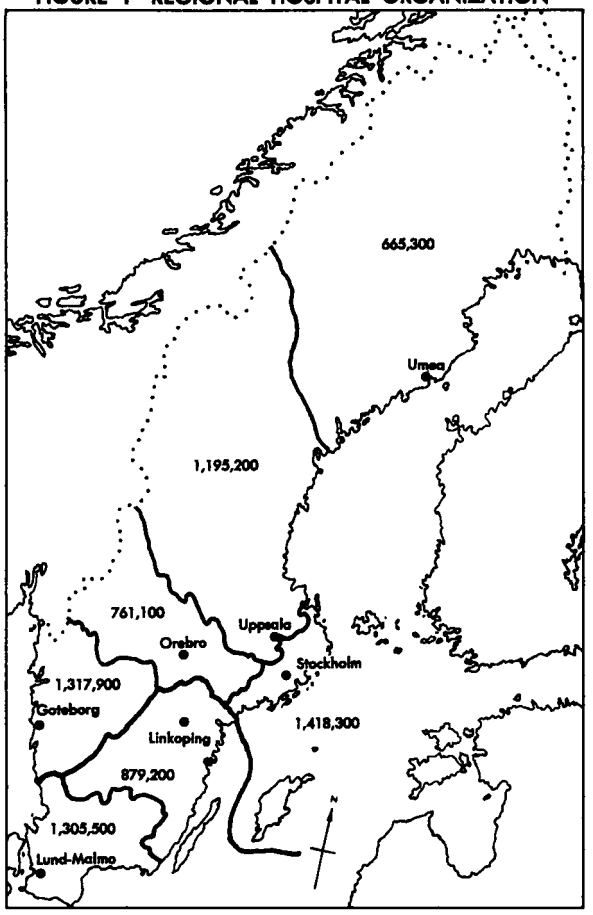
I was now appointed by the government to study this situation more closely. My work resulted in a recommendation of a regionalized hospital system where three to four counties operated on a voluntary basis to provide the supraspecialty services at *one* hospital—the regional hospital. This hospital was carefully selected—if the site was not predestined, as in the case of the existing teaching hospitals. Socio-economic development, population, migration, and quantitative changes were studied in cooperation with Professor S. G. Godlund, Professor of Economic Geography, to find the best composition of the regions and the site of the regional hospital. Communications were, of course, also considered.

A Parliamentary Act of 1960 recommended the county councils to cooperate inside seven hospital regions, to provide their populations with the most specialized clinical services at regional hospitals, all according to the regional hospital plan. The regional hospitals, which are not yet teaching hospitals, have become university clinics or are looked upon as potential ones.

Figure 1 shows the medical "administrative" division of Sweden today, with the seven hospital regions, each covering three to four counties. The populations of the regions vary from about 700,000 to 1,500,000; the higher figure is preferable.

Collaboration inside the regions is on a voluntary basis. The county which owns and runs the regional hospital has an agreement with the

FIGURE 1—REGIONAL HOSPITAL ORGANIZATION



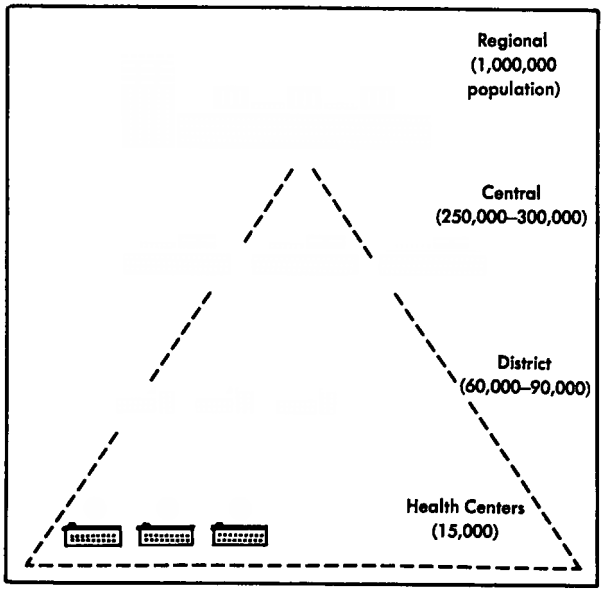
other participating counties guaranteeing a fixed number of beds in the "regional" specialties for each county. The owning county is reimbursed by the "guest" counties per occupancy day. In principle the amount to be paid covers current operational costs plus investment expenditure. A special standing committee of representatives from all member counties acts as the agency of cooperation. The hospital regions are thus functional regions or "communities of solution."

Let me now demonstrate our health organization by means of a diagram showing our four levels of organization of hospital care and of public, extramural medical care in Sweden (Figure 2).

The region (*the inter-county level*) is an area that in respect of health facilities should be independent and self-supporting, and indeed the appropriate level at which to develop operational planning of health services.

At the next level—*the county level*—we find *the central hospitals* of the counties; these institutions emerged during the late twenties and the thirties, and are more and more becoming the leading centers for all medical and socio-medical activities inside the counties. They comprise, as a rule, 800–1,000 beds, large outpatient departments (typical of Swedish hospitals), a rehabilitation center, mother and child welfare services, family planning and advice centers, a dental clinic, a nursing school, etc. We think very highly of this integration of preventive and curative services, of social and educational activities.

FIGURE 2—ORGANIZATIONAL LEVELS OF HEALTH SERVICES



Among the different services should be observed departments for psychiatry and for child psychiatry. Much importance is placed on the close integration of somatic and psychiatric care.

At *the next* organizational *county level* are the "normal hospitals"—*the local district hospitals.* These have for many years been a headache to the national health administration. Many of them have been too small, or served too small a population, or have been badly located. They do not meet the requirements of modern surgery and therefore cannot give emergency service around the clock, and so on. They have been difficult to staff, especially as regards doctors. Our policy—carried on against remarkable resistance from local authorities and the local press—urgently stressed that all hospitals should have specialized departments for surgery, medicine, anesthesiology, X-ray, obstetrics and gynecology, pediatrics, psychiatry, long-term diseases (geriatrics mainly), with a total of about 300 beds. The population in the area to be covered should be at least 60,000 and preferably 90,000 inhabitants. The other district hospitals should be converted into nursing homes for long-term diseases, or health centers, or—even better—a combination of both, which has been found to be very rational, and which is indicated on the diagram.

We have now reached the lowest organizational level for public medical care—*the local communes* with each *health center* serving a population of 10,000–20,000 with ambulatory preventive and curative care. These centers, still under development, are not part of the hospital organization, but our aim is to integrate their activities as closely as possible with the nearest district hospital. A goal, as yet nowhere achieved, is to have an exchange of medical personnel,

primarily doctors, between the hospitals and the health centers. I nourish the hope of having our health centers staffed, in the future, with physicians who are specialists (in internal medicine, pediatrics, obstetrics and gynecology, psychiatry), with a doctor of social medicine as a coordinator and leader. This would mean a more effective pattern of medical practice.

Private Practice

With regard to private practice, we encourage the establishment of group practice, preferably by specialists. I feel that it is true already, and will be more so in the future, that no doctor can cover the whole rapidly-expanding field of medicine as a diagnostician and therapist of all kinds of illness. This includes even the so-called minor diseases, or rather what are thought of as minor diseases.

The private practitioners have the right to send their patients for any kind of examination to the outpatient departments of the hospitals; it may be for consultation with a specialist, X-ray, laboratory work, or other. The expenditure is settled between the hospital doctor in charge and the patient, who is subsequently reimbursed by the health insurance.

Whole Health System Used for Education and Training

The regional hospital plan has without doubt established a good framework for the further growth of the hospital system, has prevented misplaced investments and duplication of services, and has promoted medical education and clinical research.

In 1966 the Chancellor of the Swedish Universities and I, as Director-General of the Board

of Health, appointed a committee authorized to review the existing plans for the education and training of specialists in different branches of medicine, and to indicate what changes in the basic training program of doctors were necessary. The committee suggested that virtually all health facilities be used for training purposes, and required 18 months' practice (half a year each of medicine and surgery, and three months each of psychiatry and general ambulatory practice) after the Bachelor of Medicine examination for full *licentia practicandi*. All levels of the organizational pyramid I discussed above would be used for teaching purposes as follows:

Regional hospital—university hospital: basic and specialized education and training

Central hospitals and some large *district hospitals:* practice in departments of internal medicine and surgery mainly

Health centers: general practice and social medicine

Influence of Factors Originating Outside the Planning Agencies

Of course, local ambitions have as always been an obstacle to rational planning. Obstacles have, as a rule, been overcome—with a few exceptions in connection with the building of small hospitals. This is due to three factors:

1. The good cooperation between the state health planning authorities and the county councils.

2. The existence of the Association of the Swedish County Councils, which has facilitated cooperation between the counties as regards, for example, the care of sick people outside the home area. (It was therefore, for example, natural for the counties to cooperate voluntarily inside the regional hospital plan.)

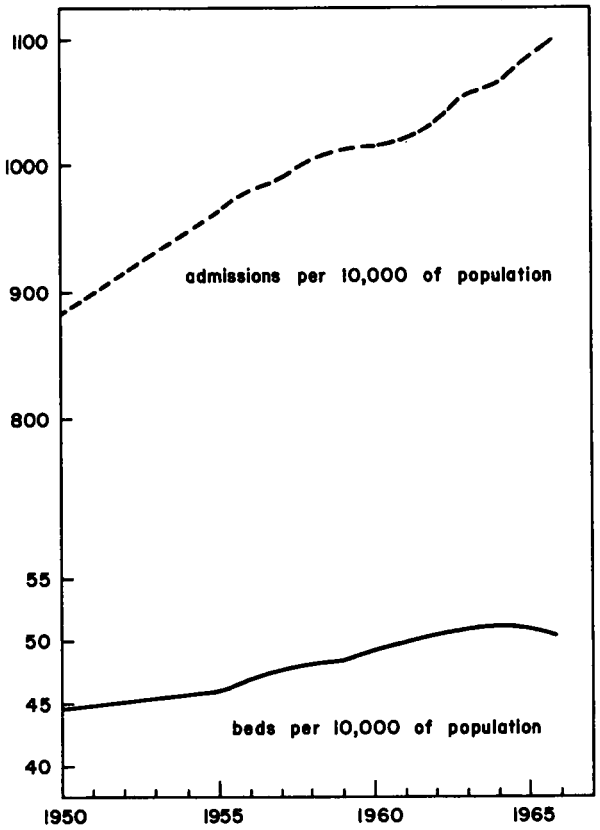
3. The self-evidence of society's responsibility to provide hospital care, which existed even before 1862 but which was then made definite, and which has prevented the establishment of private, church, insurance-owned or other types of hospitals in general, and particularly outside a rational hospital system.

This should not give a picture of too rigid planning by the state and county authorities. The initiative is very often taken on a local level by hospital boards, medical staff members, etc. New specialties thus often originate from a locally prominent doctor's activity, and his technical and administrative ability. Important pressure groups have been the sick and disabled people themselves, through their own voluntary organizations. First should be mentioned the associations for the disabled—the blind, the deaf, the orthopedically, neurologically, and mentally handicapped. This is the field where voluntary action has been most frequent and successful. The trade unions also have been very active in planning, especially for the prevention of occupational diseases. Health and welfare activity in this country is not only a concern of the professionals and politicians; it is deeply rooted in the humanism of the Swedish society.

Impact of Health Insurance on Consumption of Medical Care

Beginning January 1, 1955, the national compulsory health insurance system offered all citizens free hospital care in all public hospitals. Medical care provided at the outpatient departments of the hospitals, at the district doctors' stations, or in private practice was, however (as noted above), not free of charge. This policy should be ex-

FIGURE 3—ADMISSIONS AND NUMBER OF BEDS FOR GENERAL HOSPITALS (EXCLUDING EPIDEMIC, LUNG AND CHRONIC DISEASES, AND MATERNITY DEPARTMENTS)



pected to promote hospital care at the expense of outpatient care.

As can be seen from Figure 3, hardly any effect was produced by insurance in this respect. The admissions rate to the general hospitals (maternity, TB, and communicable diseases, as well as long-term illness treatment are excluded) remained virtually unchanged. The number of beds per 10,000 was steadily increasing during this period, except for 1964 when smaller hospitals and cottage hospitals were changed into homes for chronic diseases and their beds transferred to long-term treatment beds.

Probably the main explanation of this absence of the increasing demand for hospital care, even though insurance became universal, is that hospital treatment has always been very inexpensive in this country. The citizens pay for their health services by way of the county council taxation.

As for frequency of physician visits, figures available from the National Insurance Board show that the burden of the rising requirement of medical care following the Health Insurance Reform mainly affected ambulatory care, but not greatly so.

As can be seen in Table A, during the first year of insurance (1955), there was a marked increase in the consultation frequency, followed by a much lower one a year later; it was 1960 before the 1955 increase was exceeded.

The drug consumption (cost and volume) showed an immediate increase that is continuing. A reform dealing with the pharmaceutical services of the health insurance—the upper cost limit for the patient was fixed at 15 Sw.Cr. (about $3) per prescription—was introduced January 1 of this year. It was at once followed by a rise in sales of 35 per cent. How long and marked this effect will be on drug consumption, we can only guess. I presume that, as with most other health insurance benefits, there will be a short initial increase, soon levelling off. We can only specu-

TABLE A—CONSULTATIONS, OUTPATIENT DEPARTMENTS OF GENERAL HOSPITALS (EXCLUDING X-RAY EXAMINATIONS)

Year	Consultations per 10,000 of population	Year-to-Year Difference
1954	5,614	
1955	5,859	245
1956	5,886	27
1957	6,007	121
1958	6,134	127
1959	6,334	200
1960	6,599	265

late on its continued impact on a health consumption that seems to increase automatically by about 3.5 per cent a year.

It is clear to me that the fear of the consumption-raising effect of health insurance has been overemphasized, not least in political quarters.

Private Action

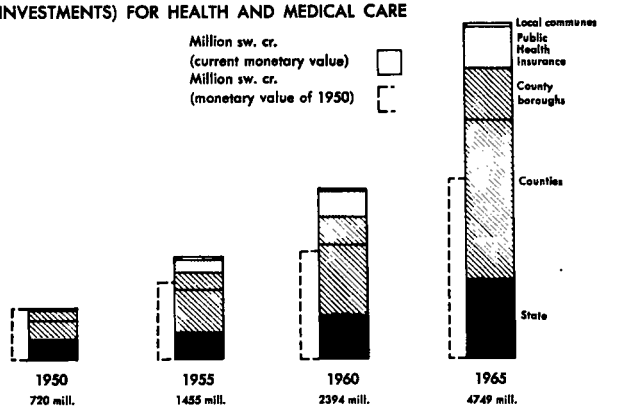
Private donors, not least of them members of the royal family, continued during the nineteenth century and even later to found new hospitals. In this way new children's hospitals, the first TB sanatoria, the first orthopedic clinics, and the first institution for crippled children were established. Those actions were spontaneous and outside official planning, but of greatest importance as pilot projects later copied by the health authorities.

Private action still occurs and private funds are raised even today to complete the public health system, but they are on a rather modest scale. The Swedish tax legislation is not really favoring such measures. Donations going to the care and education (rehabilitation) of children are here in the best position. This fact has contributed to channel such gifts to pediatrics. To run private hospitals in Sweden is hardly possible without considerable support from public funds because of the high running costs (170 Sw.Cr. average for general hospitals) and the competition from the public hospitals where the care is completely free.

I feel nevertheless that we shall continue to need private action and means for creating new pilot projects without delay, even if they are becoming more and more limited and will be functioning temporarily before being taken over by society.

There is, however, one medical activity where private funds are still greater than state contribu-

FIGURE 4— PUBLIC EXPENDITURE (OPERATIONS AND INVESTMENTS) FOR HEALTH AND MEDICAL CARE



tions, and that is medical research. I feel this is a very appropriate and beneficial way to use private initiative, to prevent bureaucracy, and to promote freedom of research.

Allocations of Funds and Consumption

The expenditure from public funds in the years 1950, 1955, 1960, and 1965 can be seen in Figure 4. The counties and county boroughs are the main contributors. The State's share has decreased relatively, to nearly 50 per cent between 1960 and 1965.

The role of the private sector of the consumption and investments for health is very small in comparison with that of the United States as can be seen from the figures below taken from the Swedish official statistics of 1965. It amounts roughly to one-third of the public sector:

	Million Sw. Cr.
Consumption and investments for health . . .	6,292
Private consumption	1,543
Thereof: Medicaments.	582
Doctors' fees.	364
Dentists' fees.	554
Other medical and personal care . .	43
Public consumption and investments	4,749*

*4,749 million Sw.Cr. = 5.7 per cent of the Gross National product.

Party Policy and Other Spontaneous Pressures

The Social Democratic Party has been in power for more than 36 years. Tribute should be paid to it for being most health-minded even at a very early date. This tendency was first observed at the local level, but the Socialist Party's health program has always been the most progressive one. In recent years, however, all parties are competing in promising the electorate medical and social benefits.

If we are looking for spontaneity in presenting specific health proposals and full programs I feel we have to turn to politicians on the local as well as on the national level—in Parliament. The importance of those voices as well as of sometimes critical doctors and laymen appearing in mass media should not be underestimated. They have been a challenge for revising old and making new plans, but their direct influence on the health programs prepared by the state and local government authorities must be regarded as very superficial. Thoughtful planning by governmental commissions and by the National Board of Health has suggested programs for the health policy of the country for enactment by the political bodies (Cabinet and Parliament), after governmental and local authorities, the medical profession and voluntary health organizations had made their comments and remarks. As the next step the county councils produce their own operational programs guided by the national comprehensive plans. Those plans are finally decided upon by the Assembly of the County Council. As the councils are self-governing, the state can hardly amend any county program. It has happened several times that the opinions of the national health authorities and of the counties have differed. This, I

feel obliged to say, depends mostly on too much local patriotism among the members of the county councils, resulting in inability to deliver. Most spontaneity in health activities has quite naturally emerged from the localities. The contributions to the development of the services presented this way, however, were never of great importance, but sometimes disturbing to rational planning.

Adaptation to the Changing Society

The changing society—the sophisticated, affluent, service-minded, service-rendering society with its increasing individual loneliness, in spite of the growing collectivism, its more and more technical, synthetic environment—is demanding from the health services a new approach with more health education, prevention, and advisory services.

Medicine and welfare can no longer be separated as community activities. In Sweden we are therefore integrating those services and have transformed the National Board of Health into the National Board of Health and Welfare from the beginning of 1968. It is especially important to achieve good health programs for children and expectant mothers, for treatment of alcoholics, narcotic addicts, juvenile delinquents and last but not least for the care of the aged—the great medical and social problem of our time.

Medical practice of tomorrow will include much more of sociology, psychology, and psychiatry. At the same time medicine will be more technological. We must therefore give the existing health workers more knowledge of sociology and psychology and make much more use of people specially trained in those fields. The highly technical methods and equipment of the hospitals

demand technicians of all ranks. Similar requirements are in the rehabilitation services—an important, expanding activity in which medicine, sociology, and technique really meet.

It is an urgent task to train a wide range of medical auxiliary personnel for the activities here mentioned.

Training programs are an essential part of the planning to guarantee both quality and quantity of health service. Long-term prognoses for the need of health personnel are decisive for the estimation of the volume of the training programs. Current statistics on health personnel of all kinds are a prerequisite for such planning and its evaluation.

The planning for health will in the future make use of much more elaborate health and demographic statistics than earlier. The planner needs to know the pattern of disease and disability, its changes and trends. He will find it useful to examine the health situation of large population groups, e.g. by mass health screening methods, and to collect current information through continuous population samples.

The application of modern scientific medicine and technology will continue to make enormous financial demands on society. Health planning as a part of national socio-economic planning will therefore be strongly insisted upon.

Many, if not most, countries are today experiencing a cost crisis in health service. In Sweden the main problem of the planner was until quite recently shortage of personnel. Now the financial problems are escalating so as to dominate the speed and volume of the development. The health services are unable to compensate for increasing running costs (in 1966 the charge per bed and day, in large hospitals, was 170 Sw.Cr. or about $34) by rationalization as in, for example, industry. Health services require enough personnel to give the patient good individual care and promote his health, and must therefore expect an increase in the salary portion of expenditures.

In addition, the costs of hospital construction are rapidly going up (over 300,000 Sw.Cr. per hospital bed today—about $60,000). We also have to face much increased expenditure for new technical devices for the disabled, which are very important and have to be given high priority.

The health services will probably be expanding for a long time before levelling off. In Sweden the share of the gross national product for health purposes has continuously increased, and far beyond predictions based on the information available in 1955.

The health percentage of the gross national product, by five-year periods, was:

1950	1955	1960	1965
2.22	2.87	4.65 (expected 3.57)	5.7 (expected 4.3)

Even if we shall be able to reduce disease considerably, and to some extent reduce the number of hospital beds, society's development requires rightly more promotion of health, better prevention of disease and accidents, more advanced rehabilitation, and much more advisory services in many circumstances of life. Science and technology will give us better but more expensive weapons, and thereby widen the activities of medicine and increase the number of people asking for medical assistance.

Those demanding medical service will include many more of the healthy population—not least, elderly persons—asking for ways and means to keep healthier and more efficient. The volume of

the obligations of medicine will therefore increase and in part assume a different character.

The limits on the endeavors to offer citizens the best ways and means to reach the complete physical and mental health that is referred to in the Constitution of the World Health Organization will eventually be set by political decisions based upon financial or manpower reasons, not medical or social.

Vigilant and flexible health planning is a prerequisite for getting effective consideration for health services, in competition with other community activities. There is not very much room for spontaneity in this procedure.

MICHAEL M. DAVIS LECTURERS

1963: Michael M. Davis, *America Challenges Medicine*

1964: Marion B. Folsom, *Responsibility of the Board Member of Voluntary Health Agencies*

1965: Dr. George Baehr, *Medical Care—Old Goals and New Horizons*

1966: Dr. Lowell T. Coggeshall, *Progress and Paradox on the Medical Scene*

1967: Dr. William H. Stewart, *New Dimensions of Health Planning*