growth by providing a legal status not heretofore contained in statutes.

Stability of Group Practice

In an attempt to determine the longevity of 98 groups studied in 1947, Hunt and Goldstein[26] found that the mean age was 19.9 years and that the oldest existing group practice was founded in 1904. No valid statistics were available to indicate the longevity of dissolved groups.

> The mean age of four voluntary non-profit hospital groups in 1947 was 28.2 years; of three industrial groups, 24.7 years; of eighty-one partnership groups, 19.7 years; of seven single-owner groups, 18.1 years, of three consumer cooperative groups, 14.7 years.[27]

Reliable statistics in the number of group practices are not available although several competent sources were sought by the writer. Rather, the stability of group practice may be defined by inductive reasoning from two points of view. The first describes the very high rate of growth of group practice. The United States Public Health Service estimated the growth of groups in 1946 over the existing number of groups in 1932 as representing an increase of 54 percent. The period to 1950 represented a 100 percent increase in the number of groups in 1932. The Group Health Institute, in 1959,[28] estimated the number of group practices at four times the 1950 estimate which was 500 groups. It should also be noted that the United States Public Health Service,[29] in 1959, reported more than 3,500 diagnostic and treatment centers, most of which would be considered group practices. Suffice it to state that the growth of group practice, during the past 15 years, has been exceptional and, from a sociological point of view, a significant trend in the administration of health services.

The second viewpoint about the stability of group practice may be defined in terms of prepayment and insurance health underwriting. These phases of health economics have represented dominant forces in public health activities during the last two decades and have represented a natural consequence to apply these economic concepts to group practice. The former has encouraged the growth of the latter. The great and demonstrative group practices of the fifties, those which comprised the American Labor Health Association and the Group Health Federation of America (now, both combined to form the Group Health Association of America) were all, with very few exceptions, representative of the application of the aforementioned economic concepts to the group philosophy. These health programs have not only grown in number, but they have grown in size and scope.

One further factor is deserving of note and that is that the large group health programs such as HIP, Rip Van Winkle, Group Health Cooperative, etc., all have a wide base of popular support and institutional standing in their communities. With the acquisition of land, property and specially built facilities, their stature and importance have increased. Truly, then, the group practices of the fifties have become institutional forces in the civic affairs of their communities and, unlike the group practices "of old," are much more than voluntary associations of doctors. Some have received special legislative charters but most are "here to stay" by the power of their broad base. The writer would liken these group health programs almost as semi-public agencies similar to the public authorities. They have an institutional flavor with considerable community support.

Functional Organization of Group Practice

The functional organization of a group practice may be viewed from several aspects. Definition of the placement of authority and responsibility with the lower levels of delegated authority described will be outlined for each of the forms of the organization. Administrative and professional officers and the functional branches of the various forms of group practice will be detailed.

As in every organizational structure, all authority and responsibility for the affairs of the group rests at the "top" of the structure. If a group practice is owned by one person, quite naturally, the owner will have all authority, and delegations of that authority would be from him to the other members of the group. The same would hold for the partnership, be it composed of two or more persons. The partners collectively would hold and delegate authority. Frequently, there is a senior-junior partnership arrangement and, in this case, the authority would rest with both. The difference would probably relate to the financial remuneration of each and possibly the extent of ownership. In larger groups of co-owners, authority of all the owners is often delegated to an executive committee or policy committee. All of the foregoing would relate to other than non-profit practices.

In non-profit group practices, it is virtually a universal truism that authority would rest with the group which fostered or sponsored the health activity. In a voluntary hospital, a board of trustees or overseers would exist. This board would, in most instances, be made up of a preponderance (if not all) of lay persons. An industrial group would have all authority