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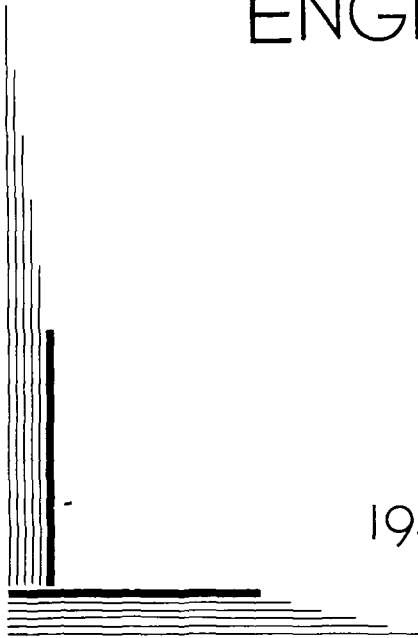
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# HEALTH INSURANCE

IN

# ENGLAND

1938

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Bureau of Medical Economics, American Medical Association, Chicago

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*Reprinted from the Organization Section of the American  
Medical Association*

*April 16, 1938, Vol. 110, pp. 183B-186B;*

*April 23, 1938, Vol. 110, pp. 189B-193B;*

*April 30, 1938, Vol. 110, pp. 197B-199B*

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535 NORTH DEARBORN STREET  
CHICAGO, ILL.

41583

# Health Insurance in England

*A Statement from the Bureau of  
Medical Economics*

Because the United States followed England in such social legislation as workmen's compensation, housing, poor laws and many forms of factory legislation, some propagandists feel it is our inevitable fate to adopt something like the English health insurance system. There are, of course, many gaps in the logic that leads to this conclusion. Some types of social legislation that have long prevailed in England have been rejected and some social legislation has originated in the United States. The conclusion of inevitability rests on the claim that present conditions in this country are identical with those that gave rise to the English system of health insurance—another supposition which is quite at variance with the facts. The "follow the leader" argument also assumes that the leader took the only possible, or at least the most desirable, road.

Before deciding that we are on a parallel road from which there is no turning, let us examine the conditions and the forces that gave rise to British health insurance as well as the extent to which it has attained its avowed objectives.

In 1909 a royal commission which had been studying the English Poor Law made its report. It has often been said that the minority report of this commission has had a wider influence on subsequent public policies pertaining to the poor than any other official document ever published. This report focused attention on poverty and all the means for its relief but was especially

elaborate in its proposals for medical care for the poor. It recommended greater extension of the public health service, with special emphasis on preventive measures—both medical and social. That those who advised another road rather than health insurance were right would seem to be indicated by the fact that present medical programs in Great Britain show a strong tendency to return to these proposals, or at least to many features of them.<sup>1</sup>

Although all shades of opinion were represented, neither the majority nor the minority report of the commission mentioned sickness insurance, notwithstanding such systems had existed in neighboring nations for nearly a quarter of a century. On the contrary, the most prominent and best informed members of the commission were among the most determined opponents of the insurance system when it was proposed by Lloyd George in 1911.

#### VOTES AND MEDICAL CARE

It now seems probable that the need for votes by certain political parties had far more to do with the adoption of sickness insurance than the need for medical care to the poor. The demands of the growing Labor party for the relief of poverty and its support of many of the measures recommended by the Poor Law Commission threatened to defeat the Liberals. The indigent who needed medical care had far fewer votes than the wage workers who were to be attracted from the Labor party by favors to the mutual aid societies.

The proposed health insurance law placed all the emphasis on cash benefits paid during illness. This naturally attracted the millions of

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1. Report on the British Health Services—A Survey of the Existing Health Services in Great Britain with Proposals for Future Development, published by P. E. P. (Political and Economic Planning), 16 Queen Anne's Gate, London, December 1937, pp. 394-395.

members in the mutual relief associations which usually were affiliated with the Labor party. On the twenty-first anniversary of the law in 1934, Lloyd George said that when health insurance was proposed nobody wanted such a law. This is not altogether accurate. Neither the indigent nor the workers nor the physicians wanted it, but the Liberal politicians, led by Lloyd George, wanted badly to sidetrack the recommendations of the Poor Law Commission and take away some of the most valuable political assets of the Labor party.

To secure the support of the unions and provident societies that expected to be the principal carriers of insurance, Lloyd George promised 9d. in benefits for 4d. in contributions. The first draft included a death benefit, but, when the powerful commercial insurance companies threatened to put all their solicitors into the field as election agents against the insurance law, this clause was promptly withdrawn. He thought so little of the provisions for medical care that he practically ignored the physicians, who almost unanimously opposed the law. Only by the efforts of the British Medical Association were the worst features changed.

#### BRITISH MEDICAL ASSOCIATION ATTITUDE

The attitude of the British Medical Association at this time is described by Dr. George C. Anderson, medical secretary of the British Medical Association, as follows: <sup>2</sup>

The measure seemed inevitable and we resolved to get behind it, counseling with the government and seeing to it that several vital principles were incorporated in order to protect the interests of the profession and public.

There certainly can be no criticism of the efforts of the British Medical Association in try-

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2. *Detroit News*, Sept. 30, 1934; reprinted in the *Journal of the Michigan State Medical Society* 33: 689 (Dec.) 1934.

ing to make the best of such "inevitable" action. The association was responsible for the most desirable features, which are most frequently listed by those who urge a similar law in the United States. Most of the credit for whatever is helpful to the people of Great Britain in the health insurance system must be given to the British Medical Association, which was faithful to the traditional principle that has dominated medical societies for centuries--that under all circumstances the best possible medical care must be supplied to the public. No matter what obstacles legislation, pestilence, flood, famine or war may place in the way, the medical profession seeks to adapt itself to the situation and gives the best service it can. It is never more faithful to this principle than when it opposes methods of organizing medical service which make it hard to provide good medical care.

#### PRE-INSURANCE CONDITIONS

The medical conditions in Great Britain, which prepared the way for health insurance and largely determined its later evolution, are significant. Medical practice in the low income classes was conducted largely under two types of prepayment contract practice. One type was composed of certain mutual aid associations and trade unions, many of which later became the carriers of health insurance; the other consisted of medical "clubs" organized by physicians, either as individuals or as groups. In both types the physician was paid in advance by regular contributions from a number of individuals. As must be true of all such schemes, the physician's income was fixed in cash, while the medical service which he agreed to give was indefinite, unlimited in quantity, and not amenable to valuation by the receiver. Competition between these various organizations inevitably was centered on price or the amount of dues. By 1910

this situation had reached its logical conclusion. Competition had forced the dues down to the point at which the physicians who served large sections of the population were paid so little that it was impossible to maintain any decent standards of medical service.

The London *Lancet* had aroused the medical profession by the publication of a series of articles entitled "The Battle of the Clubs," which showed that the physicians had been reduced to the verge of starvation and the service to a point at which it was almost valueless. A more subtle, but even more deadly, effect on medical standards was produced by the destruction of public knowledge of or interest in good medical service. Instead, the public had been trained to accept a superficial service and to judge all medical care by its cost.

#### A DANGEROUS PARALLEL

These conditions do suggest the possibility of a deadly parallel, against the approach of which the United States may well be on guard. Continuous expansion of forms of contract and prepayment plans under such titles as "medical cooperatives," mutual benefit associations and advertising medical groups has already developed a strong trend in this direction. The hue and cry about the "high cost of medical care" which such plans are supposed to reduce is setting up a monetary standard by which to judge the quality of medical service. Such competitive appeals on the basis of price to a public unable to judge the quality of medical service will inevitably make the cheapest and poorest service the "fittest to survive." Under such circumstances medical service follows a sort of "Gresham's law," according to which the poorest drives out all the better grades. When this stage was reached in England, health insurance became "inevitable."

The Friendly Societies and trade unions, which were operating the largest prepayment schemes, were attracted by the promise that they would operate the system and that the contributions of the employers and the state would double the benefits that they could distribute to their members. The first proposal followed the Continental pattern and placed the distribution of medical services as well as cash benefits in the hands of these "approved societies." Against this provision the British Medical Association raised such strenuous objection that it was finally abandoned. While the societies still control cash benefits, the medical service is managed almost exclusively by physicians, with the important exception that the amount of payment is fixed by the government.

The medical profession was promised that the commercialized medical clubs and other systems of contract practice would be abolished.<sup>3</sup> As a matter of fact, "with regard to medical benefit, under the act it was frankly a perpetuation of club practice on a vast scale."<sup>4</sup>

#### INSURANCE NOT PREVENTIVE

In appeals to the public and the profession, much was made of the promised preventive character of insurance and its tendency to improve the general health of the working population. The rapid industrial rise of Germany, which was then worrying English industrialists, was credited to the effect of insurance in maintaining the health of German workers. A clause was inserted in the proposed law pretending to penalize institutions and localities maintaining harmful health conditions; this clause was first ignored and then repealed. Its best friends now admit that, so far as prevention is concerned,

3. Williams, J. H. Harley: *A Century of Public Health in Britain, 1832-1929*, London, A. & C. Black, Ltd., 1932, p. 46.

4. Williams,<sup>3</sup> p. 48.



insurance has been a conspicuous failure. "The hope that the imposition of a compulsory National Health Insurance would achieve the principal purpose for which it was instituted, namely, 'the prevention of disease', has been largely disappointed."<sup>5</sup>

It was thought that free access to physicians would encourage such measures as immunization. Because underpaid and overworked physicians could scarcely be expected to be interested in such activities, the results were again disappointing, as is shown by the following statement from a British health official:<sup>6</sup>

At long last this country is really waking up to the importance and safety of Immunization against Diphtheria. America has been some ten years ahead of us in this matter, due to a certain extent to the American flair for wholesale publicity together with a more polyglot population in its big towns that is more susceptible to flamboyant methods of propaganda than our more sober-minded and less emotional people. . . .

As a contrast compare London with 1 per cent of its school population immunized with New York State, where the numbers immunized exceed 700,000. We have no figures in this country that can compare with those on the other side of the Atlantic. None of us who are immunizing on a larger scale here can approach the figures in some of the American towns where diphtheria is being steadily eliminated. Take Hamilton, Ontario.

In 1922 there were thirty-two deaths from diphtheria, when immunizing was begun.

In 1925 the deaths had dropped to fourteen; in 1929 to one; in 1930 there were two, and in 1931 there were none at all. . . .

Just as I finish writing this paper, the *Medical Officer* of the 12th May reports that "The diphtheria ward of the Alexandra Hospital at Montreal has been closed because there are not enough cases to warrant it being kept open. It was in 1928 that immunization against diphtheria was started in Montreal. The death rate that year was 28 per 100,000. In 1929 it fell to 15, in 1930 to 10, in 1931 to 6, and in 1933 to 2. Last year 52,063 Montreal children were immunized.

5. Graham-Little, Sir Ernest: Medical Education and the Public Health, *Journal of State Medicine* 42:75 (Feb.) 1934.

6. Nash, Elwin H. T.: The Present Position of Diphtheria Immunization, *J. State Med.* 42:522 (Sept.) 1934. See also Panel and Contract Practice, *Lancet* 2:675 (Sept. 22) 1934.

The Committee on Scottish Health Services of the Department of Health for Scotland reported in 1936<sup>7</sup> that:

Apart from the efforts of a few local authorities, little has been done in Scotland to encourage and provide for immunisation of the general population against diphtheria, scarlet fever and other diseases.

Specialists in tuberculosis charged that the proper treatment of sufferers from that disease has actually been hindered by the Insurance Act:<sup>8</sup>

It is not at all unlikely that the unfortunate administrators of the Act, from those at the Ministry of Health to the tuberculosis officers and the panel doctors, realize that they have to cope with a Frankenstein monster created when the National Health Insurance Act came into force in 1912.

Patients with cancer and tuberculosis still come to institutions too late for helpful treatment, and the percentage of cases overlooked in the stage when treatment is most needed is fully as high as in the United States.

#### DOES NOT CARE FOR INDIGENT

Insurance still leaves the indigent to the care of voluntary institutions, gratuitous service by physicians, and the legal relief of the Poor Law. Public expenditures for indigent medical care have increased steadily until England has now entered on a program that involves the greatest expenditures in her history and includes the establishment of publicly owned hospitals with a greater bed capacity than that of all the voluntary hospitals combined. Medical care of the indigent is also being reorganized in various other directions, some of which are much like

7. Committee on Scottish Health Services Report, Department of Health for Scotland, Edinburgh, 1936, pp. 197-198.

8. Shaw, H. Batty: "G. P.'s and T. B.: An Indictment"—The Answer, *Brit. J. Tuberc.* 28:49 (April) 1934. See also Watt, James: The National Tuberculosis Scheme—The Experience of Twenty-One Years; Residential Institutions, Transactions of the Twentieth Annual Conference, National Association for the Prevention of Tuberculosis, England, June 14 and 15, 1934, p. 82.

those proposed by the Royal Commission on the Poor Law in 1909 and which were sidetracked in 1911 in favor of health insurance.

An estimate of the annual cost of health services in Great Britain gives the figures reproduced in the accompanying table.<sup>9</sup>

This expenditure of more than \$900,000,000 is equal to an annual per capita expenditure of a little less than that of the per capita rate in the United States. The value of such a comparison may well be challenged because of differences in purchasing power of money,

*Annual Cost of Health Services in Great Britain*

Expenditures for	State and State Insurances, Millions of Pounds	Voluntary and Private Enterprise, Millions of Pounds
Doctors.....	12	38
Medicines.....	25	25
Dentists.....	2½	7
Other ill health services.....	41½	22
Insurance cash payments (including adminis- tration).....	30	7
	86	99
	185*	

\* This sum represents about one twenty-fifth of the national income. (The left-hand column covers governmental and the right private expenditures.)

standards of living, quality of medical service and numerous other elements, but when these are all considered the conclusion as to comparative costs still seems sound.

GAINS FROM HEALTH INSURANCE

What has England gained from health insurance? It would be as foolish to deny there have been any gains as to accept the ridiculous claims of American propagandists. The British Medical Association did introduce some elements into the insurance law that greatly improved the

9. Report on the British Health Services, p. 391.

previous forms of club practice, but citizens of the United States can scarcely comprehend the sort of medical service that contract practice had forced on the low income classes in England in the first decade of this century. It was inevitable that insurance—or almost any change—should improve the condition of physicians in urban districts working for these clubs. The “sixpenny doctors” who were performing practically all types of medical service for a uniform fee of a little over ten cents could hardly have found any change to their disadvantage.

There are many physicians with comparatively small panels and with considerable additional private practice who are so devoted to professional ideals that they supply all their patients—whether panel or private—with the best service of which they are capable. Here insurance is largely incidental and the results are primarily due to the survival of private practice.

There is no doubt that British systems of medical education prepare their graduates to give good service and that the majority of their graduates will do their best to maintain high professional standards even under the handicaps of insurance.

To judge correctly the probable effect of insurance on medical practice in the United States, conditions in England in 1911 must be compared with those in the United States at present.

The question must be faced as to whether sickness insurance encourages good medical practice or fosters superficial diagnosis and treatment.

An investigation by Lloyd George to determine the per capita charges which should be made under insurance showed that the average annual per capita collections from private patients prior to insurance amounted to 4s. 2d.,

and, with deductions for bad bills, just 3s. That a decent medical service or a decent income for physicians could have been provided from an annual per capita expenditure of approximately 75 cents is inconceivable. Yet the fact that the per capita payment under insurance was finally set at 8s. 6d. (a trifle over \$2) is hailed by the advocates of insurance in this country as a great victory for the British Medical Association.<sup>10</sup>

#### REPORT OF ROYAL COMMISSION

When a royal commission investigated national health insurance in 1926, it brought in a decidedly laudatory report and listed the following as the principal achievements of the system:<sup>11</sup>

(a) Large numbers, indeed whole classes of persons are now receiving a real medical attention which they formerly did not receive at all.

(b) The number of practitioners in proportion to the population in densely populated areas has increased.

(c) The amount and character of the medical attention given is superior to that formerly given in the best of the old clubs, and immensely superior to that given in the great majority of the clubs which are far from the best.

(d) Illness is now coming under skilled observation and treatment at an earlier stage than was formerly the case.

(e) Speaking generally, the work of practitioners has been given a bias towards prevention which was formerly not so marked.

(f) Clinical records have been or are being provided which may be made of great service in relation to medical research and public health.

(g) Cooperation among practitioners is being encouraged to an increasing degree.

(h) There is now a more marked recognition than formerly of the collective responsibility of the profession to the community in respect to all health matters.

10. Orr, Douglass W., and Orr, Jean Walker: Now They are Ahead of the Public, *Survey Graphic* 27: 83, 118 (Feb.) 1928.

11. Majority Report, British Medical Association to the Royal Commission on National Health Insurance, p. 34.

At first glance this looks like a formidable list of achievements. When analyzed in detail, it gives rather the appearance of a frantic search for every favorable item. Because this list is so constantly repeated in American publications urging that we follow England's example, it is worth a little further examination:

(a) The first statement implies that "large numbers, indeed whole classes of persons" formerly did not receive any "real medical attention." This is undoubtedly true and so, therefore, is the conclusion that those who had nothing before are getting something now.

(b) Is anything really gained by increasing "the number of practitioners in proportion to the population in densely populated areas?" One of the indictments brought against conditions in the United States by insurance advocates is that medical services are already too highly concentrated in densely populated areas.

(c) It would be hard to imagine a medical attention that would be inferior to that formerly "given in the great majority of the clubs." Here is simply a repetition of the first claim that something added to nothing produces an increase.

(d) It would be a real achievement if the observation and treatment of illness at an earlier stage were truly efficient. The failure of the insurance system on the preventive side raises some doubts as to the validity of this statement. It is also rather hard to reconcile this claim with the constant and rapid increase in disabling sickness among those who receive this treatment.

(e) This is only a general opinion of the commission, which is disputed by some authorities. It may be accepted as true if we note that the comparison is with the "bias towards prevention which was formerly not so marked." It would be hard to find any "bias towards prevention"

in the old club practice. This is the familiar formula - nothing plus something equals more.

#### CLINICAL RECORDS OF INSURANCE

(f) The medical writings of England will be searched in vain to find any use in research of those "clinical records" provided by insurance which are "of great service in relation to medical research and public health." The morbidity statistics coming from insurance sources are so distorted by the influence of certification for cash payments that they serve only to confuse the whole field of vital statistics. Those who have tried to use insurance records for clinical research report that they are more concerned with dates of certification, number of prescriptions and other matters required in the administration of the scheme than with clinical or pathologic conditions of the patients.<sup>12</sup>

(g) If "cooperation among practitioners" is of sufficient value to be listed among insurance achievements in the report of a royal commission, there should be some explanation of the nature of that cooperation. A reading of British medical journals indicates that the greatest increase in cooperation is in defense of the interests of the physicians against actions of the government and the approved societies.

(h) This seems to be another indefinite generalization illustrating the persistent search of the commission to find something which could be said in favor of sickness insurance.

The question might be raised as to how much of whatever actual gains are listed are really due to insurance. During the last twenty years the science of medicine has made remarkable progress in insurance and noninsurance countries alike, and there is much evidence that this progress has been more rapid in Canada and

12. Lockhardt, L. P.: Industrialized Man and His Background, *Lancet* 1: 826 (April 21) 1934.

the United States than in most of the nations having systems of sickness insurance.

It is almost impossible to prove any statements concerning the actual character of the medical service under British health insurance. There is no doubt that certain practitioners are giving the best service of which they are capable. It is also probable that the best service is given where insurance plays the smallest part—that is, where panel patients are few and private patients dominate.

#### INSURANCE AND HOSPITALS

The British system supplies only a "general practitioner service." It has no provisions for hospital, laboratory or consultant services. In fact, the existence of insurance sets up some quite definite obstacles to obtaining such additional services. This condition in itself would tend to encourage a neglect of serious cases in which such additional services are most valuable. The insurance physician is inclined to send all serious cases to the hospital. One result of this is such an overcrowding of the hospitals as to cause an extreme delay in the admission of those needing hospitalization. In Scotland we learn that: <sup>13</sup>

The average waiting period for diseases of the nose, accessory sinuses, and tonsils and adenoids was 70.1 days; for hydrocele and varicocele, 62 days; hernia, 37 days; gynecological affections, 35.5 days; nonmalignant tumors, 29.3 days; varicose veins and ulcers, 26.9 days; hemorrhoids, 23.3 days; chronic appendicitis, 21.5 days; gastric and duodenal ulcer, 20 days.

Although propagandists for sickness insurance in the United States assure us that the panel service is so satisfactory that "The Workers Say, 'Yes—and More,'" <sup>14</sup> yet actions of the public in patronizing the outpatient depart-

13. *Committee on Scottish Health Services Report*, p. 231.

14. Orr, Douglass W., and Orr, Jean Walker: *The Workers Say, "Yes—and More,"* *Survey Graphic* 27: 37, 52 (Jan.) 1938.



ments of hospitals tell a different story. "It was expected that general practitioner service under the National Health Insurance Acts would gradually deplete the outpatient department"<sup>15</sup> says an editorial writer in the *Lancet*. But this promise also failed of realization, so that "At the present time nearly 4½ million new out-patients attend during the year at hospitals in England and Wales, and, while in the last decade the number of such new patients in London has increased by 10 per cent, the number of attendances has increased by nearly three times that percentage."<sup>15</sup>

It is easy to secure conflicting testimony as to the extent to which overworked panel physicians are compelled to give superficial service. The number of patients on the panel, the extent of the additional private practice, and the character of the physician himself are elements which vary so widely that no absolute answer applying to all practices is possible.

The average panel contains about 1,000 persons, each of whom requires an average of a little over five attendances yearly, either at the home or in the physician's office. If sickness were spread equally over the whole year, there would be no absolute necessity of hasty action, but investigations have shown that two thirds of the medical attendance is required during one half of the year. During the busy season about 3,200 attendances are required during 150 working days, or an average of a little over twenty-one visits per day. If even one third of the physician's time is required for private practice, the time available for each visit is certainly all too short for any thorough diagnosis. But the limit of a panel practice is 2,500 patients per physician, and in the crowded centers, where the type of patients live for whom insurance is most frequently urged, there are numerous panels of

15. *Lancet* 1: 29 (Jan. 2) 1932.

around 2,000. Such a physician would have over forty attendances per day even if he had no private practice and paid no attention to the dependents of his panel patients.<sup>16</sup>

#### VISITORS FIND WHAT THEY WISH

It is not surprising that such conditions cause American visitors to give contradictory reports concerning the character of British insurance medical service. Each one finds and describes what he wishes. One reports that all the panel practices that he visits show excellent service and satisfied patients and physicians. The next one describes crowded waiting rooms and the "look-and-a-bottle" type of diagnosis and treatment. That there is plenty of the latter type is indicated in the pages of the British medical journals that sincerely defend the system and seek to improve and perfect it. Sample quotations from some such comments by British physicians are given:

What is the general practitioner in England today but a glorified first-aid man? Quack patients beget quack doctors. It is a question, from the general practitioner's point of view, of getting as many patients as he can on his list and getting the consultations over as fast as he can. Only by such means can a living be made. If the doctor comes across an illness which may interest him, had he the time and were he reasonably paid to treat it, he simply refers the patient to the nearest hospital; insurance committees do not encourage academic excursions by general practitioners. . . .

Any intelligent nurse could run a panel practice successfully.<sup>17</sup>

My surgery hours are cluttered up with people who certainly would not come so often or drink so much medicine if they had to pay even one penny a visit. I cannot do otherwise than rush them through. Those

16. As to number of visits, see Memorandum by Insurance Acts Committee of the British Medical Association, Supplement to the *British Medical Journal*, May 29, 1937, p. 315. See also letter from Dr. Alfred Cox, *British Medical Journal*, Oct. 3, 1936, p. 694, and letter by Dr. R. N. Porritt, *The British Medical Journal*, Oct. 10, 1936, p. 711.

17. *British M. J.* 2: 562 (Sept. 12) 1936.

who are obviously ill, or who fail to regain good health after a reasonable lapse of time, are examined more carefully at home or out of surgery hours; but this method is only a makeshift, and I remember with dissatisfaction two carcinomata of the stomach recently diagnosed too late and a latent pulmonary tuberculosis labeled neurotic.<sup>18</sup>

Indeed, it is very difficult to find time and energy to read and think about my patients. And even when I do, economic considerations often restrict me to the palliative bottle of medicine. Indeed, I wonder if panel treatment is intended to be more than symptomatic. Of about one hundred formulae for *misturæ* in the N. H. I. Formulary some fourteen are "cough mixtures"! How many dyspeptics can afford artificial teeth? How can one get a walking caliper for a fractured neck of femur? How can one treat the host of psychopathic cases when neither the patient's approved society nor the regional medical officer seems to care a jot about treatment?<sup>19</sup>

Some American observers—and they are supported by such good authority as the Royal Commission and many English writers—declare that there is no difference in the treatment given to panel and private patients. On the other hand, a British panel practitioner writes:<sup>20</sup>

To pretend that panel and well-to-do private patients can be treated identically is to be an ostrich. Unpleasant facts must be faced. Much national health insurance practice consists of futile efforts to adapt the patient to a wrong environment by generous doses of drugs and other poisons. We are in a changing era. Public and private health are slowly merging. Perhaps in the meanwhile the national health insurance practitioner is doing useful work which will be facilitated by the gifts of hypocrisy or self deception.

#### A PRACTITIONER'S EXPERIENCE

Another practitioner describes his experience in a somewhat facetious strain:<sup>21</sup>

It was years and years and years ago when I joined the panel, and I have to make the awful confession

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18. Brit. M. J. 2: 650 (Sept. 26) 1936.

19. Brit. M. J. 2: 786 (Oct. 17) 1936.

20. Brit. M. J. 2: 787 (Oct. 17) 1936.

21. Supplement to the British Medical Journal, July 24, 1937, p. 78.

that I thought we were supposed to treat panel patients just like our private patients. Of course it was silly, but I did not know any better. I was given a tremendous lot of pamphlets to read, but they gave me rather a headache, so I put them in the wastepaper basket and went on being silly. I used to treat their fractures, inject their varicose veins, and give them anesthetics when they wanted their abscesses opened, and even take x-ray photographs sometimes. I did all kinds of things like that. Of course it didn't pay. I worked it out once with a ready reckoner that I was getting about 1s. 6d. a time, whereas my private patients paid 3s. 6d. or 5s., or even more sometimes. It didn't seem quite fair, but then I read somewhere that poor old England was very hard up and we had to do this work for next to nothing so as to be patriotic, and I liked being patriotic, so I thought it was all right. . . .

So now I do what I am supposed to. I only treat cases of influenza, catarrh and rheumatism. I send all the others to the hospitals, where they have flag days and things to get the money, so they are all right, of course. It makes it very much easier, and now I have lots of spare time, so I use it to put in ever so many ticks on the record cards, because I understand the Minister likes ticks, and I like to please him. But the lovely part is, of course, that nobody knows any medicine that is any good for influenza, catarrh or rheumatism (or they didn't when I was at the hospital—but then I'm old fashioned), so I don't prescribe any medicine at all.

Many similar criticisms could be quoted from British medical publications that favor the continuance and expansion of the present system. A Canadian observer, who while studying for higher medical degrees during two years in England acted as a locum tenens in three widely separated and divergent panels, and who therefore had a little better opportunity than an American visitor to judge the system, gives another opinion: <sup>22</sup>

I found that a respectable livelihood can be made by the medical man with a full panel, but only by neglecting careful scientific investigation and treatment of his patients. I know one Canadian who went to England to take higher degrees and who was

<sup>22</sup>. Letter from R. K. Magee, *Canad. M. A. J.* 38: 188 (Feb.) 1938.

obliged by economic pressure to take a panel practice. He now has four surgeries, two assistants, and is making more money than he would in Canada. But he has been obliged to forego any pride in scientific care of his cases. The busy panel practice resolves itself into a "Clearing Station." The only major decision made is whether the patient is really ill or not. If he is really ill he is sent to the local hospital, and the expense and responsibility are shifted to that quarter. If he is not considered to be really ill some of the panel prescriptions will be prescribed.

A South African physician, after an examination of the English insurance system made with a view to its introduction into South Africa, says: <sup>23</sup>

The institution of the panel system as it works today in England would not be a help but a tragedy for the medical profession in this country.

#### EXCESSIVE PRESCRIBING

Such reports of experience by panel practitioners appearing in publications favorable to sickness insurance are certainly far more reliable evidence than interviews by American investigators with officials and panel practitioners or questionnaires among the insured, who cannot judge the service they receive. There are other sources of qualified opinions of the service. Almost every official report or private comment on the insurance medical service complains of excessive prescribing. For example, nearly every annual report of the Ministry of Health repeats this complaint. In discussing the report for 1935, a writer in *Public Health* says: <sup>24</sup>

In the section on the Insurance Medical Service, which provides medical benefit for nearly sixteen million people in England and Wales through some 16,600 medical practitioners, attention is again drawn to the great increase in the number of prescriptions issued, an increase which is not accounted for by any known

23. South African M. J. 7: 679 (Oct. 28) 1933.

24. The Report of the Chief Medical Officer for 1935, Pub. Health 50: 112 (Jan.) 1937.

fact relating to the incidence of disease in the country. Not only is there no contention that the expenditure of some two and a quarter million pounds on the provision of medicines is necessary or desirable, but on the contrary it has been repeatedly stated by representative practitioners that a very large proportion of the present physicking of the population is wholly unnecessary, and that, if all doctors felt themselves free to order only such medicinal treatment as in their unfettered professional judgment they considered necessary, the total cost of prescribing would at once fall spectacularly— as far, some assert, as to half its present dimensions.

The Report of the Ministry of Health, 1936-1937, says: <sup>25</sup>

The total cost of drugs and appliances supplied to insured persons unfortunately continues to rise, the average number of prescriptions per insured person entitled having increased from 4.60 in 1935 to 4.72 in 1936. Representatives of the medical profession have agreed that the consumption of drugs could well be reduced without any detriment to the patients and have agreed to cooperate with the Department to that end.

#### RESTRICTIONS ON PRESCRIBING

The attention of those who claim that there is no interference with prescribing is called to the statement on page 189 of this report <sup>26</sup> that:

Regional Medical Officers paid 891 visits in 1936, compared with 840 in 1935, to doctors whose prescribing appeared to call for explanation.

While the English hold up Scotland as an example where "Scottish thrift" has reduced the worst abuses of such excessive prescribing, the Scottish people themselves still consider that they are far from conquering the abuse.<sup>27</sup>

The statement that doctors do not feel themselves "free to order only such medicinal

25. Eighteenth Annual Report of the Ministry of Health, 1936-1937, London, 1937, p. 187.

26. Eighteenth Annual Report, Ministry of Health, p. 189. See also McCleary, George F.: The Influence of the Medical Profession on the English Health Insurance System, *Milbank Memorial Fund Quarterly* 13: 23 (Jan.) 1935.

27. *Lancet* 2: 1007 (Oct. 21) 1936.

treatment as in their unfettered professional judgment they considered necessary"<sup>28</sup> also contradicts those who report that there is no restraint on prescribing. Such restraint is most harmful and irritating. It is exercised by the patient, who insists that the physician yield his judgment as to the remedy needed and enforces this insistence by a threat to change his panel.

Every physician will recognize that a condition in which the number of prescriptions is almost equal to the number of office and home visits is an indication of superficial medical practice. Physicians who wish to retain patients on their panel find themselves subject to a pressure that they cannot well resist. One panel practitioner, who says that he believes in the necessity of "some form of compulsory national health insurance,"<sup>29</sup> offers one explanation of what has often been called the "medicine complex" of insurance patients:

One of the great sources of excessive prescribing troubles is in connection with the great demands for cod liver oil and malt, and liquid paraffin. A script for a pound of the former is worth about a shilling and for a pint of the latter about eighteenpence. Panel patients demand these things in order to barter the prescription for other things they need. This abuse was further encouraged by the offer of free gifts by chemists to persons who brought panel prescriptions to their particular shop.<sup>30</sup>

Another standard that may be used to measure the efficiency of a medical system is the morbidity and mortality statistics. British medical science and art have shared in and contributed to the marvelous advances during the last twenty-five years. In addition, Great Britain has devoted a larger percentage of its national income than almost any other nation to housing, social insurance, school medical

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28. Report of Chief Medical Officer,<sup>28</sup> p. 112.

29. A. G. P.: This Panel Business, London, John Bale, Sons & Danielsson, Ltd., p. 28.

30. A. G. P.,<sup>29</sup> p. 43.

service, improved nutrition and other forms of social legislation designed to improve living conditions. In spite of all these measures, the decline in the maternal and infant, as well as the general, death rate has been no greater and has reached no lower level than in the United States or Canada without sickness insurance.

#### MORBIDITY AND INSURANCE

Nor does the general health of the people appear to have improved even at as great a rate. Over 50 per cent of all the volunteers for enlistment are still rejected for physical or medical reasons.<sup>31</sup> It is generally admitted that the morbidity statistics are extremely discouraging. In a "Presidential Address on a Coming-of-Age: Promise and Performance" of the national health insurance system, the chairman of the Manchester Insurance Committee says:<sup>32</sup>

The incidence of sickness is still high, and on the voluntary side of friendly society work it is higher than before the Act of 1911, with a decreasing membership paying for sickness benefits. We have been spending large sums each year on medical benefit, yet the expenditure on sickness and disablement claims has considerably increased. Each epidemic leaves the incidence of sickness at a higher "permanent" level than previously. In the light of these facts, what have we gained? Is the provision made adequate to the needs?

The number of days lost by the insured now reaches fourteen days per person annually, as compared with less than ten days shown by the available statistics in the United States. It is true that a recent report says that "health insurance records, unfortunately, cannot be taken as an index of changes in the nation's health,"<sup>33</sup> but this is a criticism of "health

31. Committee on Scottish Health Services Report, p. 80.

32. *Journal of the Royal Sanitary Institute*, 54: 219-222 (Oct.) 1934.

33. Report on the British Health Services, pp. 383-384. See also President's Address, National Conference of Industrial Assurance Approved Societies, Sixteenth Annual Meeting, Nov. 25, 1929.



insurance records" rather than a defense of insurance medical service. However, as this report recognizes:

The amount of sickness and disablement benefit, and the number of cases treated has steadily risen since the scheme started, but other evidence does not suggest that sickness is more prevalent. Such an increase was to be expected in the earlier years of the scheme, since the original participants were all in employment and therefore contained a very low proportion of the unfit. But this should have worked itself through by now.

Recent studies in Scotland show the same tendency toward increased morbidity under insurance.<sup>34</sup>

If more evidence were needed to prove the falsity of the frequently made claim that British physicians and patients are all favorable to the plan, it could easily be supplied. American investigators who fail to find it must have a strong will to be blind.

#### HOW PHYSICIANS VOTE

There is still another way of judging whether there is universal approval on the part of the physicians. Every British physician votes on whether he approves panel practice for himself. It is difficult to get any exact figures on how many are entitled to practice and, therefore, to vote in this continuous election, as there is no such professional medical directory as is issued in the United States. The generally accepted figures place the number of such practitioners at between 33,000 and 41,000.<sup>35</sup> Of these, 19,000 have placed their names on the panel. It would therefore appear that only a little over one half or two thirds—if salaried employees of health and other governmental

34. Sixth Report on Incapacitating Sickness in the Insured Population of Scotland during the year 1st July 1935 to 30th June 1936, Department of Health for Scotland, Edinburgh, 1937.

35. Report on the British Health Services,<sup>1</sup> pp. 111-112. See also A. G. P., <sup>2</sup> pp. 192-193.

departments are excluded—have voted for panel practice for themselves. Many of those who register are primarily private practitioners but place their names on the panel to accommodate insured patients. The voting is somewhat dictatorial, since the physician who votes “no” loses the patronage not only of the insured, which amounts to nearly half the population, but, in most cases, of their dependents also.

This situation creates a harmful cleavage in the medical profession. The “Harley Street” physicians and nearly all of those who have attained sufficient reputation to secure a paying private practice are practically shut off from the whole insured population except for treatment in voluntary hospitals. Panel practitioners seldom have an opportunity to consult or even associate with the best trained and ablest members of the profession. Whatever American admirers of insurance may report, “panel doctor” is not an honorary title.

An editorial in the *Birmingham Medical Review*<sup>36</sup> makes some comments that are highly illuminative of professional and public attitude toward health insurance:

Just where are we? The industrial population of this country is dependent, for its doctoring, in the first instance on the Panel Service. Is that Service adequate? I say, quite definitely that it is not. It provides no facilities for specialist help, either diagnostic or curative. It does provide a G. P. service of a sort. Any panel patient can go to his panel doctor expecting a reasonable diagnosis, a prescription, maybe a sick note; just that. But a little doubt is creeping into his mind. He has an idea, which is growing, that his prescription is unlikely to be a very good one; that his sick note may be questioned. . . .

The whole panel system today is suspected. That may not be very apparent generally; but we panel doctors know it is so. I say that deliberately. And I assert that the fault lies, very largely, at the door of officialdom. The official is concerned, quite obviously, with cost. His constant inquiry is, “Why is this

<sup>36</sup> *Birmingham M. Rev.* 10: 65 (June) 1935.

money being spent?" The R. M. O. goes to his Centre and does his best to see whether this sick man, that sick woman, is, or is not, incapable of work. His concern is with sick pay. He goes to the doctor's surgery and asks, "Is this expenditure on drugs defensible?" His job is essentially financial.

#### INSURANCE AND GRADUATE EDUCATION

The overcrowded condition of insurance practice and its isolation from the body of private practitioners may be responsible for the fact that there appears to be much less interest in graduate instruction among panel practitioners than the rapid advances of medicine during recent years make essential if a good service is to be rendered.<sup>37</sup> Many members of the profession and the public have become conscious of this defect and the government has recently undertaken a program of "Refresher Courses for Insurance Practitioners."<sup>38</sup> It has been decided that this "course should be one of fourteen days" and that at present it should not be "available to any one individual more often than once in five years, or until five years after qualification." Even with these limitations, the facilities that have been so far arranged are totally inadequate to supply such courses to the great body of panel practitioners for several years. In the Annual Report of the Ministry of Health for 1936-1937<sup>39</sup> it is stated that the grants in 1936 "enabled 91 doctors to attend short courses of post-graduate study."

Organized medicine in Great Britain shows almost no sign of the intense interest in and extensive program of graduate education for the general practitioner that characterize a majority of the state medical societies in the United States. Local, and even national, meet-

37. Balme, Harold: The Development of Post-Graduate Medical Education, *Brit. M. J.* 1: 105 (Jan. 21) 1933.

38. Dain, H. Guy: Refresher Courses for Insurance Practitioners, *Birmingham M. Rev.* 12: 165 (Sept.) 1937.

39. Eighteenth Annual Report of Ministry of Health, <sup>38</sup> p. 188.

ings of British medical organizations composed of general practitioners are so occupied with discussions of insurance rates and problems of administration that little time is left for medical science and practice.

All these elements appear to have resulted in paralyzing progress within the insurance system and to have barred the insured from the benefits of medical gains to such an extent that A. A. Ritchie, in his presidential address to the Scottish Association of Insurance Committees, asked:<sup>40</sup>

Was it not tragic to think that the benefit provided under the Act today was exactly the same as it was at its inception twenty-five years ago—a general practitioner's service? Was it not tragic to think that the splendid discoveries and achievements in the realms of medical and surgical service were denied to insured persons, who without assistance were unable to obtain advantage of them?

The British Medical Association has made heroic efforts to bolster up, patch up and supplement the insurance service. It has organized a "reduced fee consultant service" in London and in some other localities. It has permitted a restoration of the condemned club practice, with, to be sure, many restrictions and improvements designed to obviate the worst of the previously existing clubs.<sup>41</sup> Finally, it is urging a complete transformation of the whole system and the introduction of many new features. The whole plan, however, must necessarily be built around the present scheme of health insurance, since this is now too firmly entrenched to be abolished or even fundamentally altered.<sup>42</sup>

40. *Pharmaceutical Journal* **139**: 380 (Oct. 2) 1937.

41. *Birmingham M. Rev.* **9**: 191 (Dec.) 1934. Memorandum on the Establishment and Development of Public Medical Services. Together with a Model Scheme, British Medical Association, London, 1937.

42. The British Medical Association's Proposals for a General Medical Service for the Nation, London, Office of the Association, 1930.

## TOO LATE TO CHOOSE

Whatever may be the truth concerning the approval or disapproval, or the success or failure, of British health insurance, the outstanding fact is that there is no longer any choice among ways of meeting problems of medical practice. Insurance is a one-way road, with few if any crossroads and no room to turn around. The United States has not yet been driven into that road, and the most important thing to ask of English experience is whether England, if it were back in 1911, would choose the insurance road. On this point an oft quoted and discussed statement of Sir Henry Brackenbury may be in point. He began a recent address on "What Is Wrong with National Health Insurance?"<sup>13</sup> with these sentences:

By this address I want to be provocative of thought. My title is not a statement, but a question; and though relative brevity must almost always lead to some appearance of dogmatism, I do not want to be dogmatic but interrogatory. First, I want to recall two passages from the Memorandum of Evidence submitted on behalf of the British Medical Association to the Royal Commission on National Health Insurance.

"The measure of success which has attended the experiment of providing medical benefit under the National Health Insurance Acts system has been sufficient to justify the profession in uniting to ensure the continuance and improvement of an insurance system.

"The organization of a National Health Insurance scheme is not necessarily, or even probably, the best means of utilizing limited resources for the promotion of national health. It is more than likely that there are a number of other directions in which, severally or collectively, a corresponding expenditure would produce an even more satisfactory return."

Those statements were made more than eight years ago. There can be no doubt, however, that contradictory as some may think them, they are both regarded as true by the great majority of the medical profession today.

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<sup>13</sup> H. Brackenbury, Sir Henry: What is Wrong with National Health Insurance, Supplement to the British Medical Journal, July 15, 1933, p. 25.

There is no question that Sir Henry approves health insurance. No one disputes that position, but this restatement and emphasis of the official statement of the British Medical Association to the Royal Commission are of especial significance to us in the United States. In his opinion, "the organization of a national health insurance scheme is not necessarily, or even probably, the best means of utilizing limited resources for the promotion of national health." The United States is just now ready to decide the question of "the best means."

The British Medical Association has recognized not only that great changes are necessary if an adequate medical service is to be furnished to all the people but also that there are great difficulties in adapting the insurance system to such changes. In a recent report of the Association's Scottish Committee,<sup>44</sup> there appears the following statement:

With all its imperfections, the present system of national health insurance has become an accepted and valued part of the national life, and preserves what the Association regards as essential factors in the relationship between patient and doctor. It would appear, therefore, to be the wiser course to provide a national medical service by the extension of the present compulsory contributory system rather than to scrap the whole of the existing machinery and proceed to build on an entirely new foundation.

It would appear that it is still a debatable question whether it might not be desirable "to scrap the whole of the existing machinery and proceed to build on an entirely new foundation."<sup>45</sup>

The most valuable lesson we can learn from British experience is not that we are inevitably doomed to adopt sickness insurance but rather just how we can escape that fate. A study of British evolution demonstrates that the intro-

44. Memorandum of Evidence by the Association's Scottish Committee—The Scottish Health Services, Supplement to the British Medical Journal, July 7, 1934, p. 1.

45. It should be noted that all criticisms of British Health Insurance in this study have been taken from governmental or professional publications that favor insurance.

duction of systems of prepayment for medical care that collect fixed cash dues and pay benefits in an indefinite medical service instead of in cash inevitably leads, first, to deterioration of the service and, second, to compulsory insurance. Not only Great Britain, but nearly every other European country, has gone through this evolution.

Voluntary sickness insurance or prepayment schemes collect cash dues of a fixed value and pay benefits in a service the value of which the receiver is unable to judge. No layman can measure, with any degree of accuracy, the value of the elements in a modern diagnosis and treatment. The only body that has ever been able accurately and impartially to make such a valuation anywhere or at any time is the organized medical profession. When judgment and control by the profession is removed or weakened, competition of rival schemes for cash income constantly compels more and more deception of the people who receive the service benefits. When such a situation becomes unendurable, the next step is to call on the state to establish a system of compulsory insurance to regulate the cash contributions. When this fails to improve the service, the medical profession is next called on to try to establish standards of medical service. This has been the course of evolution pursued in every country with compulsory insurance, and when this stage is reached the profession always does the best it can but is then so hampered by government interference and the effect of years of false education of the public concerning medical values that the end is worse than the beginning. It is then too late "to scrap the whole of the existing machinery and proceed to build upon an entirely new foundation."

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**2003-04**