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Sickness
Insurance
Catechism

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Sickness Insurance Catechism

1. What Is Sickness Insurance?

Sickness insurance is proposed as a method of distributing the economic burden of sickness. The first purpose was to distribute the burden of unemployment due to sickness. This is still the controlling motive in most of the systems and absorbs the larger part of their resources and determines their organization and administration. Medical service in the beginning was looked on primarily as a means of reducing the burden of cash payments during sickness. This pattern still dominates, although the medical service is now urged as the principal objective. The administrative machinery is still designed to collect, manage and distribute cash. It is in no way suited to administer a medical service.

2. How Does Insurance Affect the Medical Service?

Medical service, unlike cash or material commodities, cannot be collected, stored and distributed without changing its qualities. Its value depends on the relations between the producer (the physician) and the consumer (the patient). Its distribution is a part of the service. The introduction of a third party who is neither physician nor patient is equivalent to adulteration of the service.

3. How Does Sickness Insurance Affect Diagnosis?

Since insurance administration is controlled by cash considerations, quantity, rather than quality, of medical service is stressed. The essentials of a good diagnosis are time, patience, careful attention to details and sympathetic relations between a skilled practitioner and a cooperating patient. Insurance compels haste and tends to create antagonism between patient and physician. By removal of the essentials mentioned, insurance delivers little more than the dregs of a real diagnosis.

The effort to substitute for these essentials something that will fit the cash standards of insurance causes exaggerated importance to be given to mathematical and mechanical analyses, pictures and measurements. But these are only one set of valuable, but often isolated, facts that must be integrated with the personal interview, history and individual examination through the knowledge and experience of the physician. Insurance tends to restrict this most vital part of the diagnosis.

4. How Does Insurance Affect Treatment?

Insurance almost inevitably leads to overmedication. It has become well-nigh proverbial that the diagnosis and treatment provided in insurance systems consists of a "look and a bottle." Insurance seeks to check the steadily rising cost of drugs by the application of cash standards through restrictions on prescribing. Since sick individuals and scientific medical service do not fit these standards, treatment is hampered while the evil of unnecessary medication remains.

5. Do the Best Physicians Enter Insurance Practice?

The Germans have a saying that "insurance service is always second class." While there are many individual exceptions, few would deny that in countries which have sickness insurance the median level of ability is lower among insurance than private practitioners. Although the British Medical Association favors insurance, and the conditions of practice are less unsatisfactory than in almost all other systems, only about half of the licensed practitioners are enrolled under the insurance regulations.

6. Does Insurance Decrease the Amount of Sickness Among the Insured?

Few achievements of the modern scientific age are more striking than the conquest of once widespread diseases in the progress of medical discovery. A host

of diseases like smallpox, yellow fever, malaria and typhoid fever, which were once among the largest causes of sickness and death, have been abolished or reduced to a fraction of their former importance. In many others, improved methods of treatment have shortened the period of recovery. While morbidity statistics are inadequate in the United States, such evidence as is available indicates a decline in the amount of serious sickness from a number of causes. Although most of the advances in medicine, together with the improvements in sanitation and public health measures that are characteristic of modern civilization, are found in countries having sickness insurance, yet among the insured under practically every system the records show a constant increase of morbidity. This increase is not entirely due to the demand for "certificates of incapacity to work," required to secure cash benefits. This constitutes such a large and growing evil that in nearly every country having a sickness insurance system there is developing a strong and increasing movement for a complete separation of cash and service benefits. The increase in sickness among the insured is due to a deep inherent evil in insurance. Various studies of fairly large numbers of patients have led to the conclusion that from 40 to 75 per cent of all illnesses are complicated by mental disturbances. Insurance methods of treatment make almost impossible the patience, time, careful investigation and lengthy care with close personal relations that such patients require. Moreover, as studies of many systems have shown, insurance actually arouses conflicts, anxieties and desires that aggravate existing illnesses and create a host of new ones which cannot be treated properly by the methods that prevail under insurance. Prepayment for medical care, especially over a long period, creates a desire to "get something back" in the form of such care. This desire to "get something back" has a tendency to create the sickness that is the condition of obtaining the coveted service. This is not malingering nor even quite the

same as the "traumatic neuroses" that cause so much trouble in workmen's compensation practice. In the latter cases there is at least a real or imagined injury as a beginning. But the cases under insurance are originated by insurance. Every sickness insurance system furnishes ample illustrations of these harmful developments. Physicians practicing in the German system estimate that from 30 to 50 per cent of the cases treated are created or aggravated by this situation. Fifty years of this system in the period of greatest medical progress in the war on disease has almost trebled recorded "morbidity" among the German insured.

7. Does Insurance Increase the Practice of Preventive Medicine?

Even the most enthusiastic advocates of insurance admit that sickness insurance has done little to develop or encourage measures for the prevention of disease. Individual immunization, regular health examinations and measures for the detection and treatment of incipient disease are, in all insurance countries, largely dependent on other agencies than insurance. The insurance practitioner is too hurried and is held too closely by restrictions imposed by administrators to give much attention to preventive work. Such preventive work is more extensive, reaches a larger percentage of the population and is better supported by the general public and the medical profession in the United States than in countries having compulsory sickness insurance.

8. Does Sickness Insurance, by Furnishing Unlimited Free Medical Service, Encourage the Detection and Treatment of Incipient Disease?

It is highly probable that even the superficial examinations encouraged by insurance methods detect some such diseases that might not otherwise have been brought to medical attention. There are many physicians practicing under insurance whose professional

integrity and scientific ability enable them to overcome the conditions encouraged by insurance and to select for thorough diagnosis those threatened by serious disease. It is somewhat significant that none of the often over-enthusiastic propagandists of insurance have ever collected any facts to demonstrate whether cancer or tuberculosis, for example, are more frequently detected at an early stage among the insured than among the noninsured. On the other hand, many physicians with experience under insurance declare that the flood of patients with imaginary or trivial complaints, or who come only to prove they are sick in order to draw cash relief or to "get something back" from their contributions, that crowd the office of an insurance physician not only compel a tendency toward hasty or superficial diagnosis but lead to suspicion of the actuality of symptoms described by the patient, and a disbelief in the existence of serious disease. The whole economic organization of insurance encourages attitudes and conditions hostile to a thorough detection of incipient disease.

9. Does Sickness Insurance Lower the Death Rate?

The progress of medical science has been marked in every modern nation by a more rapid decline in mortality during the last half century than in any of the preceding centuries. The application of the triumphs of surgery, epidemiology, immunization and the advances in diagnosis and treatment in a multitude of directions has added a score of years to the average life. Where these advances in medical science have been utilized in public health work and private practice it is possible to demonstrate statistically their effect in reducing the death rate. But the advocates of insurance have not been able to show a similar statistical connection between the introduction or extension of insurance and a decline in the death rate.

10. Does Sickness Insurance Reduce the Cost of Medical Care?

Before this question can be answered properly it is necessary to have some comparative standards of medical care. These do not exist. It is certain that the first effect of insurance is to divert a considerable share of the contributions for medical care to costs of administration. In Germany (almost the only country where such statistics are available) there are more sickness insurance administrators than physicians in the scheme. The physician must spend a considerable portion of his time as a routine clerical worker filling out the numerous blanks and reports required. Not only is this a wasteful use of professional skill but it still further reduces the already scanty time available for medical service and prevents the continuous study essential to *good* medical service. While no comparative statistics are available, and probably would be impossible to gather, all obtainable information seems to lead to the conclusion that, considering all national differences, no less sums are spent for medical care for the insured than are spent by the uninsured, with the same economic resources.

11. How Are Physicians Chosen for Insurance Practice?

There are wide differences in the various systems. In some there are so many restrictions and conditions that the physician is practically selected by the administrators. Where this is true and insurance is compulsory for a large portion of the population, it amounts to a secondary system of licensure, the conditions of which are acceptance of rules and regulations often established for reasons other than the furtherance of good medical practice. In the French, English and Scandinavian systems any licensed physician may enter insurance practice by simply agreeing to meet the conditions set up by the law.

12. How Do the Indigent Receive Medical Care Under Sickness Insurance?

Insurance leaves almost untouched the entire problem of care for the indigent sick who are not eligible to the benefits of sickness insurance systems. In no country has it perceptibly decreased expenditures for this purpose.

13. What Has Been the Effect of Insurance on the Medical Profession?

Economically its first effect in many countries was to increase somewhat the incomes of physicians whose practice was largely confined to the low income classes. Many patients who had hitherto paid nothing for medical care now had something paid for them through insurance. Later, in most systems, the income of physicians in insurance practice was reduced and at the same time the field for private practice had become so contracted that the total average of income was lower. Almost any system would have improved the conditions of English physicians where "medical clubs" prevailed. The members of these clubs paid a few cents weekly or monthly for which physicians agreed to give a sort of medical care. One of the arguments for insurance was that it would abolish the abuses of the "clubs," but these are now returning on a large scale in spite of insurance, and bringing nearly all the old abuses with them. In England, where only the actual worker and not his dependents are covered by insurance, the average income of panel physicians from insurance is little over \$2,000 a year, out of which he must pay the expenses of his practice. These physicians still have some private practice, but proposals now being considered to extend that system will further restrict this field of independent private practice. The panel physician is paid a little over \$2 per person annually and must therefore have approximately 1,000 persons on his panel in order to receive \$2,000. Payment for physicians under the English system is generally

considered to be better than under any other system. The number of persons per physician in the United States is a little over 800.

14. What Is the Effect of Insurance on Graduate Study of Physicians?

Medical progress is so rapid as to require constant study by the physician who wishes to use the most approved methods of diagnosis and treatment. Many state medical societies in the United States spend a considerable amount of their time and energy in furnishing their members with facilities for postgraduate study and in encouraging their members in all forms of professional improvement. Administrators of insurance systems also encourage a form of graduate study. They establish institutions to teach how to make out insurance reports, to detect malingering, to keep down the cost of prescribing and to meet the regulations provided by insurance. The physician who spends his time in this kind of study has little additional time left from his overworked insurance practice to keep up with scientific advance.

15. Has It Been Possible to Apply a Uniform Health Insurance System Throughout the Countries in Which These Systems Have Been Adopted?

In nearly every country, local conditions have forced modifications of the general plan. The mountainous sections of Switzerland, the Highlands and Islands of Scotland, the farming sections of France and the miners of Germany are examples of conditions where the general system had to be greatly modified or entirely discarded to meet local conditions. There are as wide diversities in almost any of the states of the United States as are to be found in European countries. It is quite certain that the best possible general plan that could be devised could not be adjusted to all the varying conditions throughout the United States or even in different sections within many of the states.

16. Who Have Been the Advocates of Sickness Insurance?

The most significant general fact is that in no country have either the physicians who are to give the service or the proposed beneficiaries of that service ever asked for it. In most countries its introduction was opposed by both groups. In a few countries in recent years, where voluntary insurance societies had been organized among laborers and found themselves in financial difficulties, these societies were able to secure the support of their members and sometimes of the political parties of labor for state subsidies and then for a compulsory system. The demand in these cases does not appear to have come from the membership but from the officials of the societies that were in financial difficulties and from the labor politicians who saw in the societies an extensive political machine. The first advocates of sickness insurance have almost always been social workers and philanthropists. These groups and individuals see in sickness insurance a simplification of their work in providing medical relief. Neither are they blind to the fact that the introduction of a system of sickness insurance will involve the employment of large numbers of such social workers.

17. Have Sickness Insurance Systems Become Involved in Politics?

In every country having such a system, the administrations of insurance have developed into powerful political machines. When benefits are distributed to individuals through an extensive administrative machinery with many employees, the whole scheme tends to become a gigantic political machine. This always has evil effects on the quality of the medical service. Patients are not able to judge the quality of medical service. They prefer free drugs to thorough diagnosis, and the politicians will give them what they want with-

out regard to the effect on their health. This has been the tendency in nearly every system of sickness insurance.

18. What Is the Position of the Organized Medical Profession on Sickness Insurance?

The medical profession has always maintained that its mission is to fight disease and guard the health of the people. It is to medicine and the scientific achievements encouraged by it that the world owes its amazing progress in the battle against disease. Organized medicine in the United States has been responsible for the origin of public health departments and the constantly rising standards of medical education, licensure and hospital practice. While every other occupation avows its mission to be the improvement of the economic conditions of its members, the medical profession has always insisted that its main mission is to protect the welfare of the individual and of the public. Individual physicians are human beings with all the weaknesses of human beings. But the organized profession has always maintained that the quality of medical service, the safeguarding of the public health, and the destruction of disease should be first. It is from this point of view and with a record of more than a thousand years of adherence to these principles that organized medicine approaches the question of insurance.

In no country has the organized medical profession declared itself against the principle of insurance as a method of payment for medical service. Nowhere has organized medicine based its position in regard to any medical question on economic grounds. The medical profession has not judged sickness insurance simply as a means for removing the economic obstacles to securing some sort of medical service. On the contrary, the medical profession views sickness insurance systems and proposals as a means by which lay interests, with a record that shows no such willingness to relinquish economic advantages as does the history of the medical

profession, seek to gain control of the practice of medicine.

Medical associations in the United States are interested in the operation of insurance systems in all other countries, not so much from the economic effect on physicians or patients (although this phase has not been neglected) but chiefly with regard to the character of the medical service given, its effect on the general health of the insured and its influence on the standards of medical practice. The medical associations of insurance countries have cooperated faithfully in trying to protect the health interests of the insured. It is significant that the advocates of insurance in the United States always offer as the best examples of insurance just those systems in which the medical associations, always only by hard fighting, succeeded in introducing provisions to safeguard the character of the medical service and to mitigate some of the evils inherent in sickness insurance. It is also significant that the same advocates oppose all proposals to include such safeguarding provisions in the schemes urged for the United States.

19. Has Organized Medicine Been Indifferent to the Problem of Medical Care for the Low Income Classes?

An estimate based on numerous though somewhat limited studies places the value of services donated by the physicians of the United States to the care of the indigents and low income classes during the last few years at about one million dollars a day. Practically every institution offering service to these classes depends for its existence on the donated services of physicians.

It is generally agreed that whatever measure of success was attained in supplying medical care to the indigent under the operation of the Federal Emergency Relief Administration was due largely to the willingness of the medical profession either to donate its services or to accept almost nominal fees. In some states, when the money was exhausted the state and county

medical societies urged their members to continue to give their services without pay, and the response indicated that in many counties one hundred per cent of the members agreed to do this. Certainly, if there is any section of the people that has not been indifferent to the problem of medical care for the indigent and low-income classes, it has been the organized medical profession of the United States. The American Medical Association and practically every state and a majority of the county medical societies throughout the entire country have given a large percentage of their attention in recent years to the study of this problem and to experiments in methods of furnishing medical care to those unable to pay for it. The most extensive study ever undertaken for this purpose was that organized under the direction of the Board of Trustees of the American Medical Association. The program of action which it is expected will result from this study will be based on more than two hundred experiments undertaken since 1930. These experiments have involved almost every principle that has been suggested for application in this field; in many cases these experiments have been abandoned because it has been proved that the methods proposed destroyed the fundamental conditions of good medical service. The opposition and criticism by organized medicine of the wholesale plans offered by social workers, philanthropists, employers, and laymen—very few of whom have proved their devotion to those in whose interest they claim to act by any such economic sacrifice as has been made by members of the medical profession—have been based on the determination of the medical profession to maintain for all the people the highest possible standards of medical service. It is no exaggeration to say that the careful study and controlled experimentation conducted in this field by the organized medical profession have far exceeded that of all other interested parties combined, and that the results promise to maintain the position of leadership which the United States has always held in regard to the supply of medical care to all sections of the American public.

Reports from many studies indicate that in spite of the amount of medical care paid for at almost nominal rates by the FERA, by far the larger portion of the care actually received by the unemployed and many

others not eligible to FERA benefits during the past few years was given without charge by physicians. Certainly if there is any section of the people that has not been indifferent to the problem of medical care for indigents it has been the organized medical profession of the United States. State and county medical societies throughout the entire country are trying to find the best method of giving good medical care to those unable to pay for it. A number of the experiments that offer the best promise of meeting this situation have been originated and are now being conducted by such medical societies. In all this discussion and experimenting, the fundamental necessity of maintaining the conditions on which good medical service depends has been kept uppermost. These experiments have shown that many of the methods of furnishing medical service by some of the proposed systems destroy the fundamental conditions of good service. For that reason organized medicine has opposed or sharply criticized the wholesale plans offered by social workers, philanthropists, employers and laymen, very few of whom have proved their devotion to those in whose interest they claim to act by any such economic sacrifice as has been made by members of the medical profession.

Additional material on sickness insurance and related subjects may be found in the publications listed below:

- ✓ 1. **A Critical Analysis of Sickness Insurance.**
- ✓ 2. **A Handbook of Sickness Insurance, State Medicine, and the Costs of Medical Care.**
- ✓ 3. **Sickness Insurance Not the Remedy.**
- ✓ 4. **Contract Practice.**
- ✓ 5. **New Forms of Medical Practice.**
- ✓ 6. **Health Insurance in England and Medical Society Plans in the United States.**
- ✓ 7. **Group Hospitalization Contracts are Insurance Contracts.**
- ✓ 8. **Prepayment Plans for Hospital Care.**
- 9. **Sickness Insurance and Sickness Costs.**

All these may be obtained from the Bureau of Medical Economics, American Medical Association, 535 North Dearborn Street, Chicago, Illinois.

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