ENGLISH HEALTH INSURANCE AND THE STANDARD OF MEDICAL SERVICE

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I find myself in this country at a time when questions of the provision of medical care for the poorer people are exciting great public interest, and I attribute that stirring of public interest in no small degree to the issuance of a dynamic document, the report of the Committee on the Costs of Medical Care. That document has been my daily reading since I received it when I landed in San Francisco nearly a month ago, and I am much impressed by the wealth of information which forms the basis of that report; and in reading it I cannot help turning my mind back twenty-five years to a time when in England there was a similar stirring of public interest which also depended upon the issue of a dynamic document, the report of the Royal Commission on the Poor Law.

That report, which appeared in 1908, reviewed not only the administration of the law relating to the indigent, but also the whole question of provision of medical treatment for the wage-earning classes, and although that report was two-fold—because, like the report of the Committee on the Costs of Medical Care, it consisted of a majority and a minority report—both the majority and the minority were agreed that the provision made for medical service to the poorer people was most unsatisfactory and that something ought to be done about it.

The majority recommended the establishment of a system of provident dispensaries. The minority recommended a great extension of the work of the public health authorities. The government decided to adopt neither recommendation but to introduce a scheme of compulsory health insurance

based somewhat on the model of the scheme which Prince Bismarck introduced in Germany in 1884.

Our scheme came into operation twenty years ago, in 1912, and I am often asked what has been the effect of the scheme upon the quality of medical service given to the wage-earners of the country.

In reply, I should explain that the medical arrangements in our scheme rest upon two basic principles: first, that private insurance medical practice shall resemble private medical practice as far as possible; and secondly, that the scheme shall provide each insured person with the services of a family physician.

Now, those are the principles on which our scheme is based, and to give effect to them two conditions are in operation. One is that every physician has a right to undertake the medical treatment of the insured person; and secondly, that every insured person has free choice of physician from among those physicians who have elected to take part in the service. In those circumstances how is the quality of medical service kept up to mark? Before I answer that I would ask how is the quality of medical service kept up to the mark in private medical practice?

Well, there are various circumstances which keep the physician up to the mark. In the first place, the physician is placed every day in contact with suffering people, and the natural reaction of a person placed in such a position is to do what he can to relieve suffering, particularly when he is in possession of special knowledge which enables him to apply himself to that end.

Secondly, the physician is essentially a craftsman. He has spent many years in obtaining facility in a highly skilled and difficult art, and he has in the exercise of his art the joy of creative effort.

Those two forces are in operation to maintain efficiency in private practice. Then there is another, the economic motive. After all, the physician who does his best for his patients and obtains results naturally will get a larger clientele. We all know, of course, that there are charlatans in the medical profession as there are in every profession, and they, too, can amass a considerable number of patients, but in the long run and on the whole, the successful practitioner is the practitioner who does his job in the most competent way.

There are these three influences tending to make for efficiency in private practice. How are those influences at all damaged under our scheme in England? Why should the insurance practitioner because he has accepted service under a great national scheme having for its object the improvement of the health of the nation, why should he, placed in contact with the suffering patient, suddenly become calloused and regardless of his responsibilities? Why should he lose the skill, the joy of the successful craftsman? I see no reason whatever, and it does not happen in fact.

As to the economic motive, that is also present under our scheme, because the remuneration and professional success of the physician depend not upon anything the government or the insurance authorities may do to him, but solely upon the number of insured persons who, in the exercise of their free choice, have chosen to avail themselves of his services.

Then there are other influences. One effect of the insurance scheme has been to create in every insurance area a committee of physicians, the local medical committee, a committee charged with definite public responsibilities. The operation of those committees has had the effect of developing a collective professional conscience in the various areas. The committees are called upon to exercise certain supervisory functions in relation to the practitioners of the area,

and we do find that they approach their public work in no spirit of narrow professionalism, but with due regard to the important public responsibilities which devolve upon them.

The creation of these committees has, in the opinion of those who are best fitted to judge, had an important effect in tending to raise the general level of efficiency of the insurance physicians.

Then again, we have what we might call the disciplinary procedure. We have fifteen thousand insurance physicians in England and Wales, and we have fifteen million insured persons. Now, whenever you get fifteen thousand persons in any rank of life you will have some whose conduct and efficiency falls below that of the standard which should obtain throughout the profession, and therefore it is necessary to give the insured person some way of expressing any feeling of grievance he may have against his physician. He has a right to complain, and if he does complain, his complaint is heard by a local committee consisting of an equal number of physicians and representatives of insured persons.

The number of complaints every year is very small, about 250, and in the majority of cases it is found that the complaint has no substantial foundation. The committee hearing the complaint, as I have told you, is a committee partly consisting of physicians, and that leads me to my last remark, which is, that in our scheme the medical profession play a very prominent part in the administration of the scheme, and particularly with that part of the scheme which is concerned with hearing complaints against insurance physicians. We find, that so far from the outside physicians engaged in this work taking a lenient and narrow professional view of the conduct of their erring brethren, precisely the contrary is the case.

I haven't time to deal with any further aspects of our

scheme. I have just dwelt on that point of the quality of medical service, and I have endeavored to indicate to you in what way the quality of medical service is maintained under our scheme, and I can say from my own personal experience, which coincides with that publicly expressed by the British Medical Association, that our insurance scheme, so far from having degraded, as is sometimes stated, the standard of general medical practice in Great Britain has, on the contrary, had a direct effect in improving it.