

THE INFLUENCE OF THE MEDICAL PROFESSION ON THE ENGLISH HEALTH INSURANCE SYSTEM

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THE inception of the English health insurance system marks the first appearance of the medical profession as an organized and effective force in political life. The plan as originally introduced by the Government into Parliament was prepared without consultation with the profession. It was modeled on the German system, and contained elements that had long been regarded by physicians as inconsistent with the provision of satisfactory medical services. At the insistence of the profession, it was radically altered; and when in December, 1911, it emerged as an Act of Parliament—the National Insurance Act, 1911—it embodied certain basic principles which the physicians in Germany and other continental countries where compulsory health insurance had been introduced had for many years striven vainly to secure. For this reason alone the inception of the system was an historic event, the significance of which is even now but little appreciated.

Health insurance as it appeared in a rudimentary form in medieval Europe and gradually developed during the Eighteenth and the first half of the Nineteenth Century, was not regarded as a means of providing medical treatment; it was essentially a form of insurance against unemployment—unemployment due not to inability to obtain work but to inability by reason of sickness to perform work. Its object was to provide money payments for the disabled wage-earner, and it developed a system of administration adapted to secure that object. But during the second half of the Nineteenth Century, and especially after the beginning of compulsory insurance in Germany in 1883, the provision of medical services was added to the payment of cash

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benefits and soon became of increasing comparative importance.

But the provision of medical services involved the employment of large numbers of physicians; and by the time the English plan made its appearance sufficient experience had accumulated to convince the English physicians that systems of administration designed to pay cash benefits were unsuited to provide medical services on a large scale, and that only by certain drastic alterations in the arrangements that had hitherto been adopted could health insurance be made acceptable to the medical profession. These alterations were based on principles formulated in the famous Six Cardinal Points of the British Medical Association, which were published in 1911 and were in substance accepted by the Government and embodied in the English national health insurance system.

One of the most important provisions was the separation of medical services from the administration of cash benefits. The plan in its original form placed the physicians under the control of the insurance societies, who were responsible also for the payment of cash benefits. The British Medical Association insisted that the physicians giving service under the system should have no direct contact with the insurance societies, but that medical benefit should be administered in each area by a local committee specially constituted for the purpose, on which the local physicians should be adequately represented. This was carried into effect and was the first expression of the modern tendency to separate the medical services side of health insurance from the cash payments side—a tendency which has been carried further in later systems, notably those of France and Norway. It is interesting to note that in the plans that have recently been put forward for discussion in the Western hemisphere, for example, the "Mutual Health Service" plan of the Michigan State Medical Society and the "Plan for Health Insurance in Canada," published last September by the Canadian Medical Association, no provision at all is made for cash benefits, compensation dur-

ing periods of incapacity being regarded as a function of unemployment, not health insurance.

We have seen that the tendency to separate insurance medical services from cash benefits first found expression in the Six Cardinal Points of the British Medical Association. It was an expression of the general principle on which the points were based, namely, that insurance medical practice should follow the lines of private medical practice. This principle necessarily involved acceptance of certain other measures of fundamental importance, all of which are embodied in the English system: (1) The right of every legally qualified physician to undertake the medical care of persons insured under the system; (2) free choice of physician by patient, subject to the physician's consent; (3) effective participation of insurance physicians in the administration of the system; (4) the method of medical remuneration in any area to be that chosen by the insurance physicians of the area. The Association concluded that these measures could best be secured by the panel system, which, under pressure from the Association, was adopted by the Government and became the method of providing medical services under the Act.

THE PANEL SYSTEM

The term "panel system" is sometimes regarded as equivalent to "insurance medical service." But this is not so. Insurance medical services may be, and in some countries are, provided not by the panel system but by whole-time salaried medical officers or by practitioners admitted on approval to a restricted list of insurance physicians. The panel system is one in which the authorities responsible for providing medical services keep a list, or panel, of physicians who choose to give service under the arrangement made by the authority. Any physician may place his name on the panel, and a patient is free to choose any physician on the panel. The panel system does not involve whole-time service; all the English panel physicians have pri-

vate practices in addition to insurance practice. Nor does the system necessarily involve the capitation method of remuneration; at the inception of the scheme the panel physicians in two areas, Manchester and Salford, elected to be paid per call, but this involved so much clerical work that after twelve years' experience they changed to the capitation method, that is, a fixed annual fee per insured person on the physician's list.

PARTICIPATION OF INSURANCE PHYSICIANS IN THE ADMINISTRATION OF THE SYSTEM

In some health insurance systems, the physicians are entirely subject to non-medical control; they do their work and receive their remuneration, but have no voice in determining the conditions under which they serve. This is not the case with the English system, which in construction, development, and day-to-day administration is stamped with the impress of the medical profession. In each local area the medical service is administered by an Insurance Committee² on which the local physicians are effectively represented, and this committee is assisted by a committee of physicians, the Local Medical and Panel Committee, which is charged with important advisory and administrative functions. Every year the Local Medical and Panel Committees hold a conference at which amendments in the regulations governing the medical service are discussed, and, if adopted, are presented to the Minister of Health by the executive committee of the conference, the Insurance Acts Committee of the British Medical Association, which is recognized by the Minister as representing the general body of insurance physicians. No change in the regulations is made by the Minister without previous consultation with the Committee. In the settlement of grievances and all other matters affecting the conditions of medical service, the system provides that the insurance physicians shall play an important part.

²There are 146 insurance committees in England and Wales, one for each county and county borough.

GRIEVANCES

If an insured person complains to the Insurance Committee that his physician has not given him proper treatment, or if an insurance society complains that a physician has issued certificates of incapacity without having examined the patient, or has in some other way contravened the certification rules, the complaint is heard by a sub-committee of the Insurance Committee, consisting of an equal number of physicians appointed by the Local Medical and Panel Committee and of representatives of insured persons, with a chairman elected by the sub-committee from the members of the Insurance Committee who are neither physicians nor representatives of insured persons. The facts found by the sub-committee must, if there is no appeal, be held to be established. Either party to a case, may, however, appeal to the Minister of Health against the sub-committee's decision, and the appeal is heard by a special tribunal constituted by the Minister, which, if the complaint alleges negligence in the treatment of a patient, must include a member of a panel of insurance physicians nominated by the British Medical Association.

QUESTIONS AFFECTING THE RANGE OF SERVICE

The English insurance physicians are all general practitioners; they are under no obligation to perform specialist services, which are defined as those "involving the application of special skill and experience of a degree or kind which general practitioners as a class cannot reasonably be expected to possess." If a question arises whether a particular service is or is not a specialist service, it is referred by the Insurance Committee to the Local Medical Committee for an opinion. Usually the opinion is accepted, but if it is not, the question is referred by the Minister of Health to an independent tribunal consisting of a lawyer in actual practice and two medical practitioners. The decision of this tribunal is final.

THE CONTROL OF EXTRAVAGANT PRESCRIBING

In all health insurance systems in which medicines are supplied at the cost of the insurance funds, some means must be adopted to check the ordering of medicines in excess of what is required by the needs of the patient. In some countries, extravagance is checked by requiring the patient to pay a substantial proportion of the cost of medicines prescribed for him; in Norway, he pays the whole cost. Under the English system, medicines are supplied without charge, and the Local Medical and Panel Committees are relied upon to check extravagance. Records are kept of the costs incurred by the prescribing of every insurance physician, and if it appears that a physician's prescribing costs much exceed those of his colleagues in the same area, he is visited by a Regional Medical Officer of the Ministry of Health, who discusses with him the causes of the high costs. If after the interview the physician's prescribing still seems unnecessarily costly, the Minister may refer the case to the Local Medical and Panel Committee, who hear the physician's explanations, and if they decide that his prescribing has entailed a charge on the insurance funds in excess of what was reasonably required for adequate treatment, they must estimate the amount of the excess, and that amount or a part of it may be withheld by the Minister from the physician's remuneration. He may, however, appeal to the Minister against the Committee's decision, and the appeal is heard by an independent tribunal of medical practitioners.

It will be seen that under the English system the checking of extravagant prescribing is an intra-professional matter. The question whether a physician has made an unnecessarily expensive use of medicines is decided not by laymen, or by medical officials, but by practising physicians.

CARELESS CERTIFICATION

An insurance physician is under obligation to issue, on re-

quest, certificates of incapacity to patients who are in his opinion incapable of work, and it has been found necessary to devise a method of checking the issue of certificates without sufficient care. The method is similar to that used to check extravagant prescribing. Records kept of the number of patients of each physician who are referred to the medical referees of the Ministry of Health for a second opinion, and of the number who cease to draw benefit after the reference either because they declare off the benefit funds on receiving the notice of the referee's examination or because they are found by the referee on examination to be capable of work. If the records of the physicians in an area show on comparison that any physician has an unusually high proportion of patients who cease to draw benefit after being referred to the medical referee, the facts relating to his certification may be laid before the Local Medical and Panel Committee for a decision on the question whether he has issued certificates without exercising reasonable care.

It will be seen, then, that the influence of the medical profession on the English health insurance system has been profound and far-reaching. The system has to a large extent been moulded by the profession, and in the administration of the medical service the profession take an important and effective part. It is largely for this reason that the system is accepted by the general body of the profession as a satisfactory method of providing medical care for those members of the community who are unable from their own unaided resources to pay for the medical services they need.