

# *Minimum Adequate Levels of Personal Health Care: History and Justification*

BRIAN ABEL-SMITH

*London School of Economics and Political Science*

IT IS A GREAT HONOR for a non-American like myself to be asked to contribute an introduction to these considerations of adequate minimum levels of personal health service. The concept has a long history and justification, and many distinguished Americans are enhancing our theoretical understanding of it. But it is in the European countries where theory has become practice, where nations have for so long been struggling to secure the provision of an adequate minimum of personal health care for the vast majority or all the population and to secure reasonable equity in the distribution of health care. Europe has had a different history and a different fundamental approach to the financing of health care. To view the subject from another cultural vantage point may help to widen the area of deliberation.

We in Europe have been following developments in the American health care debate with great interest. We admire the United States' high standards of medical technology. We also admire its enormous capacity to innovate new types of programs, though we find it quite impossible to keep fully informed about all that is going on. And we marvel at the intellectual ingenuity that has gone into the design of so many radically different schemes for reform that are now lying on the table—some for long enough to have accumulated their fair share of congressional dust.

As I understand it, there is concern that the United States is spending a great deal on health care—about 8½ percent of the gross national product—without achieving either an acceptable degree of equity in health care distribution or anything like the standards of health that might be expected to flow from such a vast input of resources. There is at the same time a political thrust to try and provide “a right to health care” for all Americans. But there is also deep concern about the financial consequences if equal distribution of health care should mean extending to all the costly services currently enjoyed by the best-provided sections of the population. There are grave doubts about the political practicability of actually delivering equity even if the funds were made available to finance the present common type of virtually open-ended insurance. And the more sophisticated are worried that the package of services that would emerge if equity were achieved would fail to conform to any rational priorities for improving the health of the American people. By giving everyone paper rights to health care, you may end up doing little better at much greater cost and feeling worse about it.

Your research studies, your paperbacks, and even your films have demonstrated to foreigners like myself the extent of the problems of equity with which you are still faced: the relative generosity of medical care rights for the aged compared with the relative lack of medical or wider health care rights for other groups, particularly children; the nearly comprehensive rights won by collective bargaining for workers in some industries compared with the absence of any employer-subsidized insurance covering workers in other poorly unionized occupations; the high cost of individual insurance that can be prohibitive for the poorer self-employed; the inequity of drawing a hard-and-fast line between those classified in different states as medically indigent and those not so classified; the contrasts between standards of care in the inner-city public hospital and in the voluntary nonprofit hospital of more affluent neighborhoods or between care in the inner-city emergency room and in the suburban medical arts building.

And last but not least, the horror for the provident middle-class family when the breadwinner exhausts his insurance rights and drags his family over the abyss of financial catastrophe.

It has become increasingly appreciated that even in a very affluent country it is not practicable for everyone to have all that could be

provided. The key to providing greater equity may be to find a way of defining the minimum that all should have. How much is enough? But how can any line be drawn between nothing and everything that the responsible physician thinks could conceivably be helpful? Is it possible, for example, to define adequacy of hospital hotel facilities or an acceptable minimum of waiting time for nonemergency care? What personal preventive services are essential or what primary health care must be provided? Are all of these necessary for an adequate minimum? Even if a minimum could be defined, would it be possible to get a savagely independent profession to cooperate in providing this minimum? Is it ethical to do so? And if one defines a minimum, how can it be secured that those who want to pay for more can get more? Has a floor also got to be a ceiling?

Before raising these questions of practicability and acceptability, we need to face the question of justification. If we could clarify why our societies should secure a right to health care for their populations, it would be easier to answer questions about what type of health care should be provided—in what quantities and to whom. Here we must distinguish carefully between arguments for regulating the supply of health care and arguments for removing or lightening barriers to use. We must not forget that the regulation of supply may be part of the process of cutting down barriers to use and of securing equitable distribution of what is intended to be available.

## Development of Levels of Provision for Social Services

The historical process by which our societies, through their legislatures, have come to decide that particular services should be provided or made available as a right, has been long and complex. Moreover, motives have often been mixed. But we have nevertheless reached the stage when some needs have become socially recognized—the need for a minimum income in certain defined contingencies; for compulsory education for all children; for the exercise of controls over the use of our environment; for the provision of a wide range of public services from roads to parks, from fire engines to policemen. In Europe, two social needs have been much more widely accepted through legislative action than in the United States—the need for a minimum of personal health care and, less successfully, the need for a minimum standard of housing.

In every field where a service is publicly provided it has been necessary to define a level of provision. This is true of a service in cash, like public assistance, as well as of a service in kind, like education. The ceiling for cash assistance has usually been determined by minimum earnings for full-time work, though exceptions have been made to treat more generously those (such as the disabled or aged) for whom work is not in prospect, or those with large families in order to prevent children being seriously deprived. Generally, it is intended that those who do not work should fare less well than those who do. This principle has a long history—provision must be “less eligible,” or worse than that of the poorest paid laborer, as our Poor Law Commissioners put it (1832–4).

Social insurance provided a way of breaking through the principle of the same local means-tested minimum for all by providing a benefit related to past earnings. The proportion of lost earnings that is replaced has in Europe tended to rise over time, most rapidly in countries that have enjoyed substantial economic growth. In the Netherlands or Germany, for example, only a relatively small fall in disposable income may occur in sickness, unemployment, or old age. But most societies try to make sure that there is normally a financial incentive to attract the individual to return to work. I say “normally” because, again, there may be exceptions where there are extra costs due to disability, or where a return to work is not in prospect, or where there is a large family (although this depends on what provision is made for children generally through family allowances or child benefits). In the case of benefits in kind—particularly health care benefits—there are no relatively simple limiting criteria.

### *The Adequate Minimum in Public Education*

A mixture of motives led to the provision of free and compulsory education. In America, where public education had been adopted by Massachusetts in 1647, compulsory and free education was seen as a vehicle for the transfer of religious belief and the integration of immigrants from many countries. In Britain, public education is generally believed to have been a response to adult franchise, though arguments for encouraging economic progress and reinforcing military might played their part. Compulsory free education came late to Britain (around 1890) after long religious disputes and heart search-

ing about this breach in the principles of *laissez-faire*. Other European countries moved more quickly than Britain and, I suspect, with less heart searching. What was taught and the standards established for schools depended on whether the school was seen as serving the whole local community or, as in the early years of education in Britain, serving only the laboring classes. Today our education services are an area where an adequate minimum is somehow defined—a compromise between the pressures of teachers, pupils, parents, and taxpayers in general. In both our societies those who want something that they see as better have to pay twice to get it. They have to pay toward the school they do not use as well as toward the school they have chosen to use.

Teaching evolved largely as a profession in an institutional setting. Well-to-do families in Europe had long used tutors and governesses to educate their children, but these teachers did not go through any system of licensure. There were at that time no County Teachers Societies, as far as I am aware. Presumably the purchasers of the teachers' services could more readily distinguish a quack teacher than a quack doctor; education was a general rather than a specialized skill. Possibly, because teachers were not organized, let alone licensed, they were in no position to decide that the corporate practice of teaching was unethical, or to insist on the continuation of the confidential pupil/teacher one-to-one relationship. One can only speculate on how education might have developed if they had. The middle classes might have bought from the insurance companies education prepayment policies that included a life-policy element with the option of a catastrophic policy to guard against the risk that the child should proceed to the Ph.D. Though the "risk" of education was eminently predictable and actuarially quantifiable up to a stated age, the private market has never achieved much more than a toe in the door. Compulsory education adopted the service model, not the insurance model, right from the start.

Somehow our societies determine how much the public sector should spend on education and how what is spent should be distributed between different levels of the educational system and between pupils with different needs. There may be some guiding norms of class size, or ratios between pupils and teachers. For example, it was long the aim in Britain to get the class size down to a maximum of forty in primary education and thirty in secondary education. We

have become, however, much less confident that cutting class size is a particularly effective way of improving educational results; anyway, the class is no longer the clearly defined unit that it once was. Somehow all the children must be taught within the numerical complement for teachers and the budget fixed by the public authority responsible for education. Thus, priorities become established. The teacher must decide how much time to give to each child whom he is designated to teach during a given period of time.

Our educational systems are not designed to maximize the educational attainment of every child, though there may be some minimum of attainment in, for example, literacy or numeracy that the system seeks to implant. There are limited job opportunities for adults who can neither read nor write; our whole way of life assumes a capacity to understand written communication and, at the minimum, to add and subtract. Yet we have in our societies adults without this minimum of competence who gained little from school because of mental retardation, a speech defect, deafness, or a variety of other causes.

Many educational systems devote most intensive resources to children with the best educational level, in contrast to our acute hospitals, which devote the most intensive resources to those with the worst health level. Educational handicap is not regarded in the same way as is physical illness. The remedial teacher is not given the same command over resources as the physician. The teacher of the mentally retarded does not get the same status as the university professor, though the task may be more demanding and the effect of not being able to function in open society more traumatic than that of getting a poor rather than a good degree. Social malfunctioning is regarded in a very different light from illness.

### *Motives for Health Care Provision*

In both North America and Europe, the beginnings of public acceptance of certain rights to health care can be found in the twin streams of the charity hospital or clinic and the Poor Law. These were services for the poor or the near poor. The provision of mental hospitals in Britain was based on the need to protect society from the mentally ill or mentally retarded person (and particularly from the possibility of his breeding) as well as to provide an "asylum" or safe

place for the patient. The first public hospitals to be available to all without charge were hospitals for infectious disease, established in 1891 in London, about the same time that education became free. The rationale here was similarly clear; treatment of infectious disease was justified by the need to protect society, quite apart from any service provided for the patient.

Paying the medical expenses for paupers was viewed as a way of reducing the cost of poor relief. But this service was a breach of the principle of less eligibility that, in time, came to be accepted. The lowest-paid laborer could not afford to pay for doctor or medicines and, as one inspector of workhouse hospitals remarked in 1866, "the lunatics are better fed, better clad, better housed and better cared for . . . than the great mass of the working classes who earn their own living" (Great Britain, Parliamentary Papers, 1966). This was even more clearly the case in the charity hospital.

In both Britain and the United States, the charity or nonprofit hospital was by far the major provider of acute care throughout the nineteenth century and the first half of the twentieth century and remains so in the United States. The major difference is that shortly after charity hospitals started in the United States they began to take paying patients who soon became the majority of the occupants of the system. In Britain, paying patients entered the system late in the nineteenth century and never became more than a small proportion of the users of the system (Abel-Smith, 1964: Chapter 9). Until World War II, it was charity that established the right to free or nearly free acute hospital care for the majority of the British population. The money that could be raised voluntarily determined what could be provided, and admissions were determined by the medical priorities as seen by the unpaid visiting medical staff. At this time there was a very small proportion of beds in private fee-paying hospitals, none of which had any real prestige.

### *The Evolution of Health Insurance*

Health insurance has also had a very different history in Europe than in the United States. It started in Europe as a blue-collar worker and consumer-controlled movement in the late eighteenth century, and earlier in some countries. The key benefit purchased was cash support in sickness. The physician was brought in and paid to certify ill-

ness and hopefully to reduce its duration by means of the drugs he prescribed. This voluntary consumer-controlled movement, without any employer contribution, covered some seven million persons in Britain by the early years of this century.

In Germany the development of health insurance was somewhat different. More and more classes of employer were required by law to contribute to health insurance during the nineteenth century, until Bismarck applied the scheme to nearly all low-income employees in 1882. By providing economic security, Bismarck hoped to contain the spread of socialism. The Sick Funds became controlled by the social partners (the employers and employees). They negotiated with physicians the level and system of payment. They also agreed to pay daily rates for public ward care in private and public hospitals. Individuals who wanted a higher class of amenities ("semiprivate" or "private") could pay extra directly to the hospital. This set the general pattern for continental Europe. In Scandinavia, as in Britain, health insurance did not cover hospital care, or made only token contributions toward it. This was because hospitals had emerged, like schools, as public services; early on, the attempt to means-test patients who used them was abandoned.

There are thus major contrasts in the evolution and rationale of health insurance in Europe and in the United States. In Europe, health insurance started as a consumer movement, while in the United States the bulk of it originated as a provider movement. In Europe, health insurance enabled blue-collar workers to buy defined minimum services, while in the United States, health insurance evolved to ensure that semiprivate accommodation could be purchased by white-collar workers.

In the United States, the providers decided what to sell through the financing mechanism they had established to pay for it. In Europe, health insurance was budget-limited—those who controlled the funds decided what to buy—though over time, providers have had a powerful influence on the buyers' decisions. The common denominator in different parts of Europe was to pay for the doctor and his drugs and for cash support in sickness. This may not have been simply because of the small role hospitals played at that time in the system of medical care. The rationale was to help workers to stay at work, to have an income when they could not earn, and to be made fit to return to work. Later the system was extended to cover



dependent wives and children. It does not surprise me that consumers focused originally on the most common risk of short-term incapacity. What is not widely known is that the same system had begun to establish itself in the United States in the early part of this century, until the organized profession ruled it to be "unethical" and stopped physicians participating in such a system. The scale on which the American consumer might have wished to purchase the insurance right to family doctor services has never been tested over a long period because the profession has obstructed the development of this practice.

### Justifications for a Minimum Level of Health Care

If I were asked today to give a justification for a developed society securing the provision of a minimum of health care, I should say that, as in the case of education, there is no one single simple rationale. First, it is clear that the rationale of protecting society from infectious disease is now of much narrower application than in the past. But this rationale does still justify a wide range of public health measures, as well as the provision of various services, such as immunization, as part of primary personal health care.

The lack of consumer knowledge is a second consideration. One cannot know how important it may be to get personal health care until one has contacted a trained health professional. I recognize that one may still not know. But the relative lack of knowledge, compounded often by a discounting of health risks, suggests that access to primary care should be part of any minimum.

Thirdly, it is widely accepted that society has a duty to protect children from the more serious consequences of having a parent or parents who are too ignorant, negligent, or poor to provide their child with a necessary minimum. This argument points to a comprehensive, if not compulsory, assessment and treatment service for children, similar to our minimum education requirement.

The fourth and more general argument is essentially based on economic security. Illness can destroy working capacity and thus seriously reduce ability to pay for health care when it may suddenly become a high expenditure priority. The major change that has occurred over the last century is the growth in the gap between average monthly income and the amount of personal health-care expendi-

ture that a physician may decide is "needed" in the course of a month. What is "needed" in this sense cannot be known in advance. This argument indicates a high priority for the coverage of catastrophic expenses, including long-term expenses, as part of any minimum. This leads to the questions of how much expenditure is regarded as catastrophic and what standard of care should be provided. To define a catastrophe in terms of the same sum of money for all does not seem to be in line with other social arrangements. It could be argued that any monthly expenditure that brings remaining income below a minimum-but-adequate level of living is catastrophic for the individual or the family. Alternatively, it could be argued that any expenditure that lowers substantially the level of income given to replace earnings is catastrophic—in other words, that free health care should be provided to those not at work who have no more than a minimum of savings. There is something paradoxical about establishing principles of minimum income without developing mechanisms for ensuring that unforeseen expenditures do not lower the income left for foreseeable expenditure below the minimum intended. Cash minima are meaningless if one does not examine how that income is likely to be used in particular circumstances. One of the reasons for providing services in kind is that what is required varies with individual circumstances that need to be professionally determined and are not known in advance.

A fifth reason is the interest that society has in the restoration of working capacity or of capacity to fulfill social function if ultimately society has decided to provide for those who cannot provide for themselves. A sixth reason is a sense of social solidarity—what none of us thinks rightly should happen to our neighbors—which in turn raises the key question "Who is my neighbor?"

But beneath all this lies the central question: What is a minimum of personal health care? Should we be talking, as I did earlier, of physician-defined needs for health care, or of epidemiologically-defined effective health care, or of the informed consumer's felt needs if it is possible to make such a concept operational in health care, or of some other definition? What the physician decides should be provided varies widely in different cultural, economic, and organizational settings. These provisions may include elements that are for the intellectual benefit or personal gain of the physician, or for his protection from malpractice suits, or for

the financial gain of suppliers who strongly influence his judgment, in addition to the elements that are solely for the benefit of the patient. Moreover, as the physician has little motivation, let alone data, on which to determine the most cost-effective way of achieving a medical outcome, there is considerable room for achieving similar results at lower cost.

## **Effect of Physician Expectations on the Level of Provision**

It is particularly difficult to think through the concept of a minimum in a society where physicians working in acute care have become accustomed to the quite exceptional luxury of expecting to use virtually whatever resources they want to use. This expectation has been passed on in medical education and has become almost enshrined as a professional ethic.

I have said that this is a quite exceptional luxury and would argue this point in four different ways. First, as I have noted, few other countries have a general system of health insurance where the cost largely determines the premium, rather than the premium determining the cost. Secondly, virtually no other occupation, professional or otherwise, has a similar expectation. The teacher, the architect, the lawyer, the accountant each has normally to keep a sharp eye on his paymaster's pocket. And no similar license is given to the road engineers, the bus drivers, the firemen, the factory inspectors, the coastguards, the swimming pool attendants, or the health educators even when they can prove that they can save life at a lower cost than can the physicians. Thirdly, the physician working with the chronic mentally ill or mentally retarded does not have a similar expectation. Fourthly, the expectation is limited to a narrow sphere, even for the physician working with the physically ill. If a physician wants to order diagnostic tests, or use surgery or pharmaceuticals or other treatments, he expects the sky to be the limit. But if he were to decide to prescribe an electric hoist, a stair lift, an electrically powered vehicle, or just a concrete ramp to enable a wheelchair patient to get in and out of his home, the physician's expectations and the public's suddenly become circumscribed. There is a strange contrast between the amount spent in the remote hope of reducing

disability compared with the amount spent to enable the disabled to compensate for their disabilities and attain greater independence and an improved quality of life. It is by no means self-evident that expenditure on one possible route to death prevention should be unlimited while others are tightly budgeted, or even that valiant attempts to postpone death at extraordinary cost are on a quite different plane from that of the prevention of poverty, crime, violence, illiteracy, or slum housing.

How does all this help in thinking through what one means by a minimum? In my values, the services of a primary-health-care team, which includes a personal physician, come first in any specification of a minimum. The functions of this team might be to provide twenty-four-hour continuing care, including a willingness to give house calls by day and by night, to provide the requisite immunization and searching assessments to children, to provide family planning services to women of childbearing age, to provide nursing in the home and regular health checks for the elderly and disabled, to give counsel to the worried and support for the dying and bereaved, and to work with the population served to improve health by encouraging greater self-reliance and changes in behavior. I see this as the essence of personal health Care. And in this context I would give *care* a capital letter. I do not believe that this floor can be established without toughly maintained ceilings on most hospital budgets and on hospital use of medical manpower.

The financial cost of this part of a minimum would not be great when viewed as a proportion of total present health-care spending. And I do not venture an estimate of what it could save in terms of hospital costs, though the saving would potentially be substantial. The major cost would not be in dollars at all but in changes of professional attitudes and expectations, in a fundamental reorientation of education purposes and processes and of public expectations of personal health care and personal responsibility.

This concept of primary care is of course not far from what some Health Maintenance Organizations (if the term is not outdated) seek to provide. But for many Americans it would be more than they are accustomed to receiving, or at least different. It would, of course, be for the personal physician to say when referral to a specialist is necessary and, in most cases, for that specialist to say when admission to a hospital is required.

## Defining an Adequate Minimum

I see the key problem as the definition of an adequate minimum for hospital care. One possible solution is for this minimum to be determined, as in the case of education, by the total budget available for the minimum—which would have to be high enough for most people to choose the minimum—leaving those who want something better to pay twice to get it. Thus, I see the establishment of a ceiling in the facilities most people use as one of the essential steps to establishing a floor and ensuring that this floor actually exists in every geographical area.

I attach great importance to defining the minimum as the services that most people use most of the time. Those who want the opinion of a second specialist or services of the most famous surgeon could go outside the system to get it. World experience suggests that services for the poorest third or poorest tenth tend to be poor services. And even if these services were not poor, they would be regarded as poor and their users would see themselves as stigmatized. You have had here the experience of the city hospital, the doctors who will not take Medicaid patients, and to some extent the veterans' services. Is it possible to ensure that most patients are treated by personal physicians plus supporting staff with negotiated maximum fees or with negotiated expense reimbursement, capitation payment, plus more modest fees? (It should never be forgotten that mixed payment systems are possible.) A minority of patients and physicians could still be outside the system. Likewise, is it possible for the majority of hospitals to provide services from budgets limited by maximum daily payment schedules if negotiated annual budgets or, better still, combined budgets for all personal and integrated health care (both physical and mental) are unacceptable? Again, a minority of hospitals may be outside the system, charging privately what the market will bear.

A limited budget forces those responsible for spending it to determine their priorities. Local politicians, consumers' representatives, local health professionals, and others working in health services may all wish to participate in the dialogue about how the money should be spent. Some priority decisions need to be made regionally to prevent the duplication of expensive equipment and to secure a concentration of rare specialties. Other decisions need to be

made more locally. This may well mean that the precise definition of what is included in a minimum varies somewhat between different parts of the country. This avoids the need for centralization and standardization. And to some extent it protects central legislators from having to define priorities in detail by directing criticism to those responsible locally for making decisions about how "their" budget should be spent.

Somehow budget limits work in education. What is different about health that justifies a different solution? Both educational care and health care can have major influences on the life chances of individuals. Somehow, as I have said, limited educational resources are distributed between competing needs in response to the pressures of consumers and the professional judgments of teachers. The result may seem to many of us imperfect but this does not mean that we would all necessarily agree on what the right distribution should be. The problem is to establish an effective dialogue in health care—on how any budget should be spent.

In saying all this I am, of course, inevitably influenced by my cultural background. And I know very well that our National Health Service, which arose out of a different history, cannot simply be imposed on a different culture. Nevertheless, in Britain we have moved to a situation where it is widely accepted that health priorities must be planned locally and nationally both between geographical areas (Department of Health and Social Security, 1976a) and between different types of health care (Department of Health and Social Security, 1976b and 1977). In the case of the financial allocation between regions, we have only this year deliberately started a planned reallocation of money in favor of regions with the lowest health standards. The formula we are using takes account of the age and sex structure of the population served, the extra costs generated for hospitals that teach medical students, and differences in standardized mortality. In the case of services, we are giving priority to the growth of services for the aged, mentally ill, mentally handicapped, and children. Plans on these questions are widely debated in both our societies, just as are educational priorities.

Rather than take the easy course of discussing the title given to me without laying answers on the table, I have set out briefly my ideas as a way of starting the discussion. Presumably a cross-cultural challenge may move America's deliberations farther along.

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*Address correspondence to:* Brian Abel-Smith, The London School of Economics and Political Science, Houghton Street, Aldwych, London, W.C. 2A 2AE, England.