Social Security and the Medical Profession

by

Dr. Jean MAYSTRE

Secretary-General of the Medical Association of the Canton of Geneva

Last year the International Labour Review *published an article by Dr. J. Dejardin, Chief Medical Director of the Belgian National Sickness and Invalidity Fund, reviewing a number of problems arising from the relationships between sickness insurance institutions and physicians in the field of social security. The author analysed the views of the International Social Security Association and the World Medical Association respectively, noted certain differences between them and advocated a full exchange of information.*

The International Labour Office, in its endeavour to assist to the full extent of its abilities in bringing about a better understanding between social security institutions and the medical profession, has now invited Dr. Jean Maystre to put forward his views on certain medical aspects of social insurance. Dr. Maystre, besides being the Secretary-General of the Geneva Medical Association, is also responsible for liaison between the World Medical Association and international organisations (including the I.L.O.) and is thus particularly well placed to make a valuable contribution to the common fund of knowledge from the enrichment of which alone a better understanding can spring.

THERE are three facets to the problem of sickness insurance: the contingency, the benefit and the financial coverage.

The first two (contingency and benefit) are variables; only the financial aspect contains any element of objective certainty, since it is conditioned by the amount actually allotted to the protection of health in the national budget. To this extent any scheme will depend on the economic situation of the community.

CONTINGENCIES

The concept of the contingency calls for a few remarks, particularly as the manner in which it was formerly understood is now undergoing a fundamental change. For a long time the word was considered as synonymous with sickness, and experience showed that the probability of a contingency arising could be predicted in a sufficiently accurate, if not infallible, manner through the use of morbidity and mortality tables, especially in the field of accident insurance.

Today, however, the word encompasses not only the need for care in case of actual sickness but periodic health checks as well. No longer does the worker wait until he is unable to work before he goes to the doctor. Living conditions have changed; the progress of education, the dissemination of knowledge, health education, books, newspapers, the wireless and the moving pictures have developed, particularly in the more advanced countries and among the well-to-do elements of the population, a feeling of anxiety which creates an increased demand for medical examinations. Modern man is kept on his guard by preventive action; thus it is natural that he should feel alarmed and uneasy and that he should allay his fears by having health checks.

The dread of disease, the natural but regrettable tendency to take advantage of anything offered at little or no cost, and recent social trends have expanded the scope of insurance—which was originally limited to the risk of sickness proper—and introduced a new factor, namely the need for the protection of health.

A recent investigation carried out in a district of a large European city has shown that out of 100 insured persons 72 saw the doctor at least once during the year; the doctor, for his part, devoted one-half of his time to the treatment of 15 out of every 100 insured persons, each of whom visited him or was visited by him ten times during the year on the average.

The demand for services rises concomitantly with social, economic and cultural standards; another reason for this rise is the widespread support given to principles embodied in the Atlantic Charter, the Declaration of Philadelphia (adopted in 1944 by the International Labour Conference) and the Beveridge Plan, all of which proclaim the right to health. There can be no question as to the high moral value of these principles, since sickness and poverty are intolerable evils destructive of physical, mental and social well-being.

BENEFITS

Let us now turn to the problem of benefits granted in the form of medical, pharmaceutical and hospital care.

Medical Benefits

Medical practice has benefited greatly from scientific and industrial progress. At the same time, however, the new apparatus which has been devised and the new methods of diagnosis and treatment which have emerged have increased the cost of medical care. This elementary and all too frequently ignored fact must not be overlooked: technological improvements, while lowering costs in industry and in trade, increase the cost of medical care, thus bringing about two diametrically opposed consequences from the financial standpoint.

In medicine new methods are frequently described as specialised, and the doctors who apply them are called specialists. The development of medicine cannot be conceived otherwise than in terms of increased specialisation requiring a steadily growing number of specialised practitioners. Existing specialties are constantly being split up into new branches: surgery, for example, now includes bone surgery, nerve surgery, plastic surgery, etc. In this irreversible trend the counterpart of improved methods is an increase in the cost of medical care, and it is clear that as specialised medicine becomes more widespread it will also become more costly. The cost of treating a given disease now has no relation to what it was at the turn of the century.

As to the alleged overcrowding of the profession, such a problem undoubtedly exists in cities and regions of advanced civilisation. In assessing the ratio of the number of physicians to the total population figure in a given area account should be taken not only of their total number but also of their distribution among the various specialties. At the same time consideration should be given to the economic and social standards of the population. Statistics show that the total number of practitioners is especially high in certain regions of Europe and the Americas; as a whole, however, the problem of overcrowding is only apparent and arises only in particular countries or areas. At the world level the problem is one of shortage and of distribution: it is indispensable to double (or indeed to treble) the present total number of doctors if medical care is to be given to the 1,500 million human beings who are still deprived of it.

Pharmaceutical Benefits

The amount of pharmaceutical benefits granted is constantly increasing and this constitutes a serious financial problem for insurance institutions. Restrictive measures have been either contemplated or put into effect with a view to reducing this budget

item, but it would be premature at this stage to discuss their effectiveness.

Other aspects of the question, however, are worthy of consideration. It may be recalled, for example, that sometimes the prescription of up-to-date medicines, particularly antibiotics, drastically affects the evolution and duration of certain diseases and restores health and working capacity within a relatively short time. In such cases it can be said that the costlier medicine sometimes leads to an actual saving.

The sickness rate may be influenced by preventive sanitation measures ; vaccination and D.D.T., for example, cut down the consumption of medicine considerably. This problem is related to that of preventive medicine and will be discussed further on.

Finally, the use of medicines raises another important problem. Twentieth-century man, particularly in Europe and America, is not as resistant as were his forbears in the face of adverse conditions. Civilised man fears disease and, in his flight from pain, seeks an artificial haven in the abundant use of medicines. This new form of drug addiction, however subtle, must be taken into account if the use of medicines is to be curtailed and if mental health in general is to be improved.

Hospital Benefits

It is extremely difficult to make a comparative study of the burden which hospital benefits place upon sickness insurance institutions. This is due to the diversity of basic data and to the fact that statistics often cover too short a period. Frequently the cost of hospitalisation per patient cannot be compared from one country to another, as the various items into which it is broken down for accounting purposes are not always the same. Furthermore, the burden falling upon insurance institutions is not the same in all countries. In some, insurance covers all hospital expenses and in others only part. Finally, an important part is played by national or regional practices : thus, in some countries specialist care is given exclusively at the hospital while in others it is given primarily outside.

A study of the trend followed by daily hospitalisation costs per patient shows that they have increased substantially, sometimes as much as ten times between 1900 and 1950 ; the increase was particularly marked during the last decade of this period.

Not all the items included in the daily cost of hospitalisation per patient have risen in the same proportion. The heaviest increase would appear to be that relating to wages of staff ; next in order come medical care and food expenses.

Furthermore, a comparison of the cost of treatment inside and outside hospitals respectively shows that the former rose more rapidly than the latter. The difference became increasingly marked during the decade 1940-50.

A cursory study of the situation reveals an apparent similarity of trends in various regions of the world, such as North America (United States), Latin America (Chile) and Europe (Switzerland).

A broad comparative study of medical benefits provided in and out of hospital would, in our view, be of considerable interest and would doubtless make for a better understanding of therapeutic requirements.

The Economic Aspect of Medicine

The problem of health is intimately related to social and economic conditions: poverty breeds disease and, conversely, disease breeds poverty. On the other hand, any action which improves health conditions reduces poverty, just as action aimed against poverty improves health conditions. Economists have drawn attention to this interdependence and have stressed the cumulative effect, whether positive or negative, of any modification of either term of the equation.[1] Scientific progress and the evolution of the concept of social security over the past few years are new developments which sanitation plans cannot afford to overlook. Wisdom and prudence require that any plan of protection be not only the result of a thorough-going preparatory study, but also be subject to periodic review in the light of recent scientific experiments and discoveries.

The aim of sickness insurance is to utilise available resources in the most efficient manner. One way of achieving this goal is to limit expenditure. In some instances statutory provisions have been formulated with a view to restricting the scope of contingencies covered; in other cases the frequency and duration of benefits has been reduced; and attempts have been made to discourage abuses by requiring the insured persons to contribute part of the cost of treatment. Efforts have also been made to economise by reducing the cost of medical, pharmaceutical and hospitalisation benefits. In short, principles of strict economy are applied to all branches of sickness insurance, including its administration.

In the light of experience, however, it has been found necessary to abandon restrictive measures one after the other, since they are overborne by the modern tendency to consider that the health

[1] See "Economic Aspects of Health", an address by Gunnar Myrdal to the Fifth World Health Assembly, Geneva, 1952, published in *Chronicle of the World Health Organization*, Vol. VI, Nos. 7-8 (special numbers), Aug. 1952, pp. 203-218.

of all persons must be protected throughout their lifetimes by making medical care of the highest standard freely available to them without charge.

Health is not something which can be measured ; its demands are unlimited. It is commonly considered, and rightly so, as a priceless possession. In practice the dictates of economy, both at the individual and at the social levels, impose restrictions which delay or limit access to treatment. The same holds true within the framework of sickness insurance, which is subject to the same dictates and the same restrictions. While the modern objectives of sickness insurance are not at present within the reach of the more advanced, let alone of the underdeveloped countries, they nevertheless represent, in the view of many, a goal to be attained. However, even the most spectacular results achieved thus far not only do not justify the conclusion that the problem has been solved, but give little hope that it will be solved in the future.

The services rendered by medicine are sometimes assessed in terms of the general economy. Production, after all, depends partly on the capacity to work and on the state of health of individuals. It is sometimes considered that the funds allotted to public health budgets constitute a sound public investment ; nor must it be overlooked that health constitutes a valuable plank in any political platform.

Some theorists consider that health might be guaranteed through relatively simple technical and administrative measures and that any individual abiding strictly by appropriate sanitary rules could be sure of escaping sickness.

The foregoing considerations do not lend substance to these theories, as far as medical care is concerned. It may be useful, however, briefly to consider another area of medicine and to deal with some of the special features of preventive as well as curative medicine.

Preventive and Curative Medicine

A study recently published by the World Health Organisation [1] contains the following information :

The use of D.D.T. was introduced in Ceylon in 1947 ; the expenditure involved came to about 22 United States cents per head in the areas treated. The over-all death rate before 1947 was between 20 and 24 per thousand. During the three years following the introduction of the treatment it dropped to between 12.6 and 14.3 per thousand. In other words, 50,000 human lives were

[1] C.-E. A. WINSLOW : *The Cost of Sickness and the Price of Health*, World Health Organisation, Monograph Series, No. 7 (Geneva, 1951).

saved each year. In the Philippines the campaign against malaria reduced the daily absentee rate in schools from between 40 and 50 per cent. to less than 4 per cent. In Saudi Arabia an anti-malaria campaign organised jointly by an industrial concern and the Government reduced the number of cases of malaria occurring among the staff of the concern each year from 2,000 to 53. The spraying of D.D.T. cost $45,000, but the saving in medical and hospitalisation costs achieved in 1950 came to $152,000 for that company alone. In the Province of Bataan the beri-beri death rate was reduced from 263 to 28 per 100,000 inhabitants by the enrichment of the rice crop.

Experiments conducted on a large scale during the past few years in underdeveloped regions have shown that a spectacular reduction of the sickness and death rates can be brought about through judicious resort to relatively simple and inexpensive means such as the use of D.D.T., better diet, sanitation in the home and health education. Preventive action improves health and from the economic standpoint is definitely profitable.

The experiments referred to cover entire regions, frequently including several neighbouring countries ; they were conducted not only by doctors but also by teams specialised in various fields such as sanitation, dietetics, health education and even aviation.

In advanced countries public health is in the hands of a central permanent administration with manifold functions. The cost of preventive medicine varies with the degree of social development and with the distribution of the population between cities and rural areas. Generally speaking, the average annual cost is reckoned at $1.5 to $2 per head. One European country, for example, spends $1.41 for cities and $0.83 for rural areas.

In Indonesia, on the other hand, the annual cost of a complete health service, including both prevention and cure, is $0.70 per head.

The following estimates are given for information ; they include essential health protection services but not medical care :

In the United States the cost varies between a minimum of $1 and an optimum figure of $2.50.

In Finland the cost was estimated at $2.10 in 1950.

In one region of Africa there is only one physician for every 63,000 inhabitants, one nurse for every 61,000 and one hospital bed for every 4,000. Malaria is endemic and affects one-third of the population. The financial resources available for health services are negligible ($0.16 per head), and the latter must for the time being be reserved for the setting up of emergency clinical and hospital facilities.

It is a relatively easy task to estimate the cost of preventive medicine and to determine the cost of a given public health scheme,

but much more difficult to estimate the cost of curative medicine. Dr. Winslow's report shows that a comprehensive scheme of health protection including both preventive and curative treatment would probably require an annual expenditure of at least $20 per person covered, between $1.50 and $2 of which would be allotted to preventive medicine. Obviously these figures do not constitute a standard applicable indiscriminately to all countries, as economic, social and cultural conditions vary in space and time. In one country with a comprehensive health service the total cost per person covered is $29, but in one of its regions expenditure on preventive medicine does not even amount to $2 per person.

These few figures are not authoritative and give only an approximate idea of the situation today. Nevertheless, it may be stated objectively that the techniques of preventive medicine are far less costly than those of curative medicine. The questions which arise are whether the ratio is actually 1 to 10, as the above examples suggest, and whether there is a basis for comparison between the results of the two different approaches.

In order to answer the latter question an indirect study would obviously have to be made of the health problem—indirect because health is not a measurable quantity—using statistical data on morbidity, mortality, and unemployment due to sickness or accidents.

The prevalence of ill-health within a given country may be expressed in figures by counting the cases of sickness and by estimating the extent of invalidity. Thus, indirectly, it is possible to evaluate the healthy element of the population. In statistical terms, physical and mental well-being is defined by a negative test, namely the absence of sickness, since health is a state which defies direct measurement.

Other methods have been used to determine the part of the cost of sickness insurance which should be allotted to each item by the use of percentage figures. For example, a formula has been devised which gives the percentage distribution of expenses relating to medical, pharmaceutical, hospital and obstetrical care. In some cases other items have been added to the list, such as administration, compensation, dental care, etc.

This type of formula has the obvious advantage of bringing out the extent of benefits granted and the particular trends in each branch; in addition, it permits useful comparisons to be made between the various countries. However, it must be applied with caution, in view of the fatal error which automatic attribution of a constant value to the equation entails, namely substitution of the economic for the health factor. It must be pointed out in this connection that the need for medical care is not a constant

but is subject to infinite variation. The equation, however, distributes cost according to the financial resources available rather than the requisites of health.

Furthermore, experience has shown that the relative weight of each item is subject to irregular variation ; reference has already been made to the striking increase in hospital and pharmaceutical costs over the past few years. If, however, a constant value is attributed to the equation, it follows that any increase in one item should be compensated by a decrease in another, which would be absurd.

Sickness insurance schemes are affected by the economic limitations of the countries for which they are framed ; these limitations justify some restriction of the availability of treatment or the distribution of benefits. In no case, however, should second-rate medical care be tolerated or doctors be prevented from fully discharging their duties to the community.

The problem of health should be discussed in its immediate context. Local conditions are important in that they determine the choice of the most appropriate methods, either preventive or curative.

In addition, however, the problem of health should be discussed in relation to other general problems such as food, religious beliefs or education ; health depends not only on medicine but on many other factors as well, and sometimes the engineer or the educator will be the person best qualified to help raise the health standard of a community.

The various points to which attention has been drawn in the preceding pages—i.e., the fact that new conceptions have modified formerly accepted principles, thus upsetting the balance of insurance institution budgets, the emergence of the concept of need alongside that of contingency, the demand for more frequent medical care and re-examinations and the resulting increase in the cost of benefits—may rightly be considered as the signs of an irreversible and genuinely progressive trend.

Logically, this rapidly changing situation is bound to make frequent review of health insurance plans necessary. Extensive comparison of the results achieved by administrations and physicians respectively will always be useful and will show which solutions are best from the standpoint of the patients.

Let us now consider the professional activity of the physician.

Medical practice may be divided into five, usually successive, phases : anamnesis, examination, diagnosis, prognosis and treatment.

Anamnesis and prognosis have remained relatively unaltered over the centuries. On the other hand, the other three phases have

undergone considerable change. Examination and treatment now rely on numerous technical devices and call for extensive scientific knowledge. Accordingly, if the highest degree of precision is to be achieved in diagnosis one physician is no longer enough, and resort to the combined knowledge of several becomes a necessity. This constitutes a justification for specialisation, which is undoubtedly an advantage for the patient ; in budgetary terms, however, such elaborate medical care inevitably entails increased expenditure.

The financial bases on which the cost of sickness and the price of health were assessed in the past are no longer adequate by modern standards : medicine as practised in the good old days has been superseded.

Furthermore, if one considers the tendency of contemporary medicine to stress the early detection of symptoms and to rely for that purpose on increasingly thorough checks, costly equipment and specialised medical knowledge, one is led to conclude that financial coverage is bound to represent an increasingly heavy burden if it is to keep pace with changing conditions.

Health is a state of precarious equilibrium in which the personal factor is all-important. This personal factor defies scientific investigation, as it is by nature irrational and cannot be measured by technical or material means.

It has been rightly said that a patient is a being who is suffering and who craves understanding and encouragement. He expects the doctor to give him a sympathetic hearing as well as the treatment he needs. The doctor should be able not only to assume responsibility for a fellow human being, but also to stand on a personal relationship with his patient. How can the doctor possibly know what is wrong with the patient if he does not know the patient as a person? It their mutual relationship involves neither confidence nor continuity, medical care is emptied of all human feeling and becomes a technical rather than a medical process.

Technical skill, however remarkable, is no yardstick for measuring the quality of medical care. The patient expects to find both knowledge and conscience in his doctor. He cannot be satisfied with care which overlooks the human element : while he may admire the doctor for his knowledge, he respects him for his conscience. Whatever the nature of the doctor-patient relationship, there is no medicine worthy of the name which does not combine knowledge and conscience. This time-honoured truth is of vital importance to human health.

Doctors are not alone in acknowledging the high moral value of this axiom : the patients themselves are of the same mind, and their collective answer to the question " What do you expect of the doctor ? " has been aptly summed up as follows : " A middle-

class person with means has always some chance of finding a doctor who will treat him as a human being. But what of the humble masses ? Are they to be abandoned to medical care of an impersonal type, technically adequate but devoid of all human feeling, which brings the patient down to the level of a nameless member of a herd ? Is it to be thought that a man without money is not entitled to be treated as a human being ? ".[1]

The axiom " science and conscience " defines an essential requisite for genuinely human approach to medicine. This axiom appears to be endorsed not only by the patients and the doctors but by sickness insurance institutions as well. One of the theses espoused by the International Social Security Association at its Paris meeting in 1953 was that physicians working in the field of social security should be fully free to follow the dictates both of their knowledge and of their conscience.[2]

The World Medical Association touches on the same subject in its Code of Ethics, which states that a doctor " owes to his patient complete loyalty and all the resources of his science ". Under the Declaration of Geneva physicians undertake to practise their profession " with conscience and dignity ".[3]

Is the gap between the theses of the two Associations so wide that it cannot be bridged ? We do not believe so : the example quoted in relation to the axiom " science and conscience " is not, in our view, an isolated case.

It is clear, however, that before any confrontation of views can take place there should be a leisurely and thoughtful exchange of information covering as wide an area as possible. This first step may prove slow and difficult, owing to the vastness of the field and differing points of view. Contacts have been established and preliminary exchanges have taken place ; others will doubtless follow. This, however, is another matter which we do not propose to deal with here.

Our aim, as stated in the introduction, was to draw attention to some of the medical implications of social insurance and thus contribute to a process of mutual information. We hope that the preceding pages will help in developing a better understanding among the men and women of our time.

---

[1] Gabriel MARCEL : " Qu'attendez-vous du médecin ? ", in *Présences* (Plon, Paris).

[2] International Social Security Association, Eleventh General Meeting: *Record of Proceedings, Resolutions, Conclusions and Recommendations* (Geneva, 1954), p. 130.

[3] " Report on Medical Ethics ", in *World Medical Association Bulletin* (Chicago), Vol. I, No. 3, Oct. 1949, p. 108.