THE PROFESSION OF MEDICINE AND THE MODERN WELFARE STATE

WITH SPECIAL REFERENCE TO THE PRESENT DIFFICULTY IN THE UNITED KINGDOM *

S. WAND

Chairman of Council, British Medical Association

This is a problem which is facing every country in the world. It is not a new problem. It is a problem that has been growing in magnitude at an accelerating rate over the past few years and continues to grow.

It was said a couple of centuries ago that you could measure the civilization of a country by the way it treated its poor. We have advanced a long way from that conception. Social security or the Welfare State is concerned with everybody; with the prevention and cure of disease, care of the young, nutrition, provision of payments during periods of sickness, retirement pensions, maternity allowances, and so on. As most of these benefits can only be provided through a nationally organized scheme, politics must play a big part—so far as medicine is concerned most doctors think too big a part.

ORIGINS

The Welfare State would appear to be a product of the second World War, but its roots go much deeper. Before the beginning of this century it was realized that much of the poorer section of the population could not afford even the most urgent medical care, and 'friendly societies' grew up which encouraged people to pay a small weekly subscription. The societies in their turn made contracts with the doctors for the care of their members at so much per week, quarter or year—the beginning of the capitation-fee system. In many areas doctors, individually or in co-operation, operated similar schemes. For the very poor there were the poor-law doctors who provided service on a part-time basis, usually at an annual salary. This was charity, and the working men, when sick, often had to fall back on this form of charity. Wages were low and a period of unemployment or sickness found them with no alternative but to accept charity. Most doctors in private practice were prepared to waive the fee in many of these cases, but in the slum areas in times of industrial depression it could be impossible for them to do this for obvious economic reasons. The hospitals played an important part but they did not provide domiciliary attendance. Maternity cases were often left to the handy woman with no medical training or qualification. It goes against the grain for a doctor to see a human being suffering without medical aid simply because there is not the money to pay for it. Many patients were too proud to accept charity.

A demand grew up for some kind of compulsory insurance which would provide sick-pay. Thus was born the Welfare State. In Great Britain, Lloyd George produced his Insurance Act; the basis of payment—part by the man whilst in work, part by the employer, and the remainder by the State—is the principle in operation in Great Britain to-day. The scheme at its inception included the lower-paid workers only (and not all of these).

But when you pay out sick benefits you need a certificate of unfitness for work and this you can only get from a doctor. When you go to the doctor you have to pay a fee, and when a workman is sick he may not be able to afford a fee. So the doctor had to be brought into the scheme. Thus began an association between doctor and State in the field of general practice, an association, partly at any rate, the result of the need for certificates. As each certificate is a cheque on sick funds, there was a call for devices to prevent laxity in certification. Diagnoses needed to be divulged. Even today, in some countries, this aspect of medical secrecy has not yet been fully resolved.

It has, indeed, been said that careless certification can be such a charge on the National Treasury that it can jeopardize a social-security scheme and that some degree of control is therefore necessary of those responsible for providing the certificates.

Pensions were also paid to old people, cash benefits to the unemployed and, in the present Welfare State, various other items such as children's allowances, subsidized foods for children,

* An address given at a meeting of the Natal Coastal Branch of the Medical Association of South Africa on 9 September 1957.

school meals, maternity allowances, retirement pensions, educational grants, and so on. With most of these no one would disagree. The children must be cared for, and the sick, and the old and infirm. Nevertheless, there can be no doubt that too extensive application of the principle of social security has taken away a measure of incentive to be self-supporting. The individual has come to rely far too much on the State to make every provision for him. The State is to make him secure (if in these days there can be security). He is apt to forget that he is the State, he has to make the ultimate provision, he has to learn to use the benefits judiciously if they are to go round.

Let us look for a moment at the hospitals. In the United Kingdom the hospitals were originally founded on charities and until quite recent times depended upon charitable bequests—except the Poor Law hospitals. Medical treatment made many advances, particularly in the field of surgery, and hospital treatment began to cost more. The standard of nursing and hygiene improved and this cost money. In the course of time Poor Law hospitals were turned into municipal hospitals paid for out of the rates. The voluntary hospitals, as the others were called, found that they could no longer continue on private benefaction even though their non-resident medical staff gave their services free, and contributions were asked for from the workers, who gave, at first, 1d. per week through contributary schemes.

MEDICAL PRACTICE IN THE WELFARE STATE

When the War ended, the British Government asked Sir William Beveridge, as he was then, to draw up a report on social insurance and this Beveridge Report was the blue print for the Welfare State in the United Kingdom. By this time many changes had taken place. Medical science had made prodigious strides. The cost of medical care had increased enormously. It needed much more personnel and equipment. The lives of the people being prolonged, there was a higher proportion of old people to be cared for, which meant more money out of the National Exchequer. Killing diseases became chronic diseases, the victim being often unable to work. At the same time changes had taken place in incomes. Income tax was levied in such a way as to have a considerable effect in the lowering of the higher incomes so that there was a much smaller disparity in net expendable income between the lowest paid worker and the highest paid executive. The result of this, coupled with the greatly increased cost of medical care, was that the number of those who could afford to make their own arrangements was much smaller. Hospital costs bounded up and up. The cost of essential modern drugs is prohibitive to most people in an illness.

No doctor will disagree with the maxim that the aim of medical practice is to deny nobody such medical care as is necessary to save his life, cure his illness or alleviate his suffering, and in practically all countries today that means an overriding responsibility for the provision of medical care, which can only be achieved by the intervention of the State, at any rate in some part. But how? How can this be achieved whilst at the same time retaining for the public and the profession that liberty and confidence which are fundamental to a proper doctor-patient relationship? It is not too much to say that most of the countries of the world have been floundering towards a solution. In many cases too much was attempted too quickly. The problem is to find a Health Service adequate in content, fair in application with no one denied for financial reasons, affording the best medical care, yet with an unharrassed and contented medical profession, having proper incentives and maintaining their proper status in the community.

A prolonged period of under-employment or under-production would have the most serious repercussions in the Welfare State. The raising of the school age and the increasing proportion of old people mean greater demands on the Welfare funds. The same factors reduce the number of those on whose efforts the size of the Welfare Fund depends.

Full employment and maximum production are therefore essential to the successful Welfare State. These factors produce consequential results in the field of medicine. In the first place the medical service must be so efficient and so easily available that the worker is not left unproductive for longer than necessary. As the doctor, by his certificate, determines the fitness of a person for work and the payment by the State of sickness benefit to the worker and his family, he is a most important person, indeed a key person, in keeping up production. It can be understood how great may be the temptation for the politician to endeavour to get control.

A policy of full or over-full employment means an inflationary trend. Industry and the worker have the means of keeping in step with inflation; so has the independent self-employed person. Not, however, those who are remunerated directly by the State, for every claim is immediately met with the cry, 'No increase! It will start an inflationary chain'.

The provision of welfare benefits by the State is a popular plank in political platforms. In the field of medical care budgets can be made of their cost, but these may easily under-estimate the considerably increased use that will be made of the medical services and the inevitably increased cost of the constant advances being made in medical science. These increased costs can be a severe embarrassment to the Government, for once the public has been accustomed to the provision of a medical service with little or no direct payment, it is very difficult indeed for any political party to bring about any contraction in the services provided. Economies must be found somewhere. The costs of treatment and the remuneration of the doctors can be challenged—how much more easily in a full-time State-controlled salaried service?

State help may mean State control. If wholly dependent on the State for remuneration the doctor and the practice of medicine are brought very close to the political economy. Because of his peculiar vocational position the doctor can be singled out for poor treatment or an intransigeant attitude. For these and other reasons doctors all over the world have been wary and suspicious, and in the World Medical Association meetings, medical problems concerned with social security have played an important part in the discussions.

PRINCIPLES OF THE WORLD MEDICAL ASSOCIATION

The World Medical Association has drawn up certain principles of social security and medical care. Briefly, in general terms, these are as follows:

Right of patient to choose his doctor and doctor his patient.

No third party to interfere between patient and doctor.

If the service is to be controlled, the control should be exercised by the doctors.

Patient to be able to choose his hospital.

Freedom of doctor to choose his place and type of practice.

No restriction of medication or mode of treatment.

Appropriate representation of doctors on official bodies dealing with medical care.

It is not in the public interest that doctors should be full-time salaried servants of Government or social security bodies.

In a social security or insurance plan any doctor to be at liberty to participate or not.

Compulsory health insurance plans should cover only those unable to make their own arrangements.

Remuneration of medical services ought not to depend directly on the financial condition of the insurance organization.

To this I would add the freedom to publish and to criticize.

Overriding all is the Hippocratic Oath.

These principles are regarded as fundamental to the best practice of medicine. Like all general principles they are to be interpreted with common sense; obviously a woman would not be able to choose to go to an eye hospital for her confinement. The underlying truths are sound. Most of them are so platitudinous that it would seem unnecessary to mention them, yet a close study will show how easy it is for them to be transgressed in a controlled service.

The basis of all medical care is a satisfactory doctor-patient relationship. The patient places himself in the hands of the doctor, confident that his doctor will do everything possible for him, and that no one will be able to interfere in that care. The secrecy of the consultation is sacred.

The doctor is prepared to devote his life, irrespective of hours of work or his family responsibilities, to the care of his patient. There can be no greater responsibility given to any man than that of having the life of another human being in his hands.

In a fully controlled service a patient might not be able to choose his doctor; a doctor might be directed where to practise; the form of treatment he has to carry out might be determined by others; he might have no say in the organization of the service;

he might have no right to publish or to criticize. He might even be compelled to divulge information received in consultation.

When the State becomes the sole paymaster the financial status of the profession is at the whim of the State, a very important matter in an inflationary economy. The doctor cannot refuse to treat patients. He cannot go on strike.

In a free-enterprize medical service a doctor will advance by his knowledge, skill, industry and personality and the patients will critically evaluate his worth. In a State-controlled service his advancement will be in the hands of others. It may be a lay, medical or mixed body, but other factors may enter. When lay bodies have had the appointment of doctors to posts in their hands, it has not been unknown for nepotism or political bias to determine the issue. At the inception of such a service the profession may be satisfied that the terms of service are satisfactory and that the full freedom of the profession is maintained, but if this freedom becomes restricted the nature of his calling and his specialized training tie the established doctor. If he dislikes working for the State or if he regards his rewards as inadequate he has not the same opportunities as others for escape. Indeed, he does not wish to escape. He became a doctor to do a doctor's job.

And so, once established, it may become more and more difficult for the doctor to resist encroachment by the State on his essential freedoms, and this is particularly the case where part or whole of his remuneration takes the form of salary. The need for the profession to be watchful, prepared and united is obvious. Once control is established it is easy to tighten the screw.

It is also possible for the State, by the use of the University grant and the subsidy to the student as well as by amendment of the law governing the criteria of admission to the Medical Register, to effect considerable increases in the number of those qualified to practise medicine.

It is of the utmost importance, therefore, that when it is found necessary for the State to play some part in the provision of medical care it shall be in such a way that the doctor can still carry out his work with freedom in the way he thinks best, that the doctors' statute shall not be reduced, and that the relationship of full confidence between the patient and the doctor shall not be jeopardized.

BRITISH NATIONAL HEALTH SERVICE

In the National Health Service in Great Britain there is free choice of doctor and patient, and the doctor in the Service has the right to practise where he wishes (except in over-doctored areas—a small number of areas determined by an independent committee, mostly medical). The doctor has full freedom in treatment and the right to publish and criticize. The profession is well represented at all levels in organization committees and there is the fullest consultation before any changes are made in the terms and conditions of service. There is also the most complete regard for the ethics of the profession.

Let us look briefly at the alternative methods of giving medical care in a Welfare State. The financial help of the State can range from a contribution to the upkeep of the hospitals to a fully organized service. The patient can be left to pay his own fees or make an independent insurance arrangement if it is available. The State can encourage such an insurance arrangement by itself making a contribution; the insurance can be made compulsory. In one country the patient makes a voluntary insurance contribution, the State makes a corresponding payment and it is left to the patient to pay the remainder. In this instance the State also provides free of charge what are called life-saving drugs.

In Great Britain everyone of working age has to pay a weekly contribution, a similar contribution being paid by the employer (or the contributor if he is self-employed). Only a small proportion of this money, however, goes to the Health Service, the bulk being used for other social security benefits. The cost of the Health Service is met very largely from general taxation monies. Before the Acts were passed, there was considerable discussion whether the Service should apply to everybody or should exclude those who were willing and able to make their own arrangements—what was called the 90% issue.

When the State pays for the whole of the Health Service, it can make some arrangement with the doctors or organize a full-time salaried service. I need hardly say that in the United Kingdom we are opposed to a full-time salaried service. I do not think that I need go further into the reasons for this.

How can the doctor be remunerated in a State-paid service? For the presiding hospital staff, for those in the public health service of the local authority, and for research workers, it must be by salary. The hospital consultant and specialist staff can be given the option of being on a full-time or part-time salaried basis with the right to private practice, beds for private patients being available for their use in hospitals under agreed conditions.

For general practitioners there are three principal alternative methods of remuneration:

1. *By salary.* This must presuppose a full-time salaried service. It must contravene many of the principles I have referred to previously. It is interesting to speculate whether, the services given being similar, a full-time salaried service would not prove more expensive than one provided in the more traditional ways.
2. *By capitation fee*, with or without a limitation in lists and a right to private practice. The doctor gets paid so much a year for each patient on his list. If the capitation fee is the same for all doctors, his only incentive is extension by increase in the number of patients.
3. *By items of service.* This was tried on a very limited scale in the early days of the National Health Insurance and was found to be subject to abuse.

In Great Britain there can be no doubt that the Service has conferred great benefits on the public, clearly shown by the use that has been made of it. The economic barrier having been removed, every member of the public can receive the fullest and most up-to-date medical care; every pregnant woman is entitled, without payment, to the care of her own doctor, midwife, consultant or hospital as required; domiciliary consultant services are available without charge and many peripheral hospitals have been up-graded (making skilled consultants and specialists more readily available). The local authorities provide ambulance service, a home-nursing service, a home-help service to give domestic help in homes when women are confined and, when available, in cases of sickness or for the old and infirm; and many other after-care and welfare services.

The doctors, having decided to enter the Service, have made every effort, as you would expect, to make it a success. The public has come more and more to rely on the doctor for every aberration from the normal and is increasingly seeking advice for the preservation of normal health and for the prevention of illness. It was expected that a free service would lead to an increase in the work of the doctor. It certainly has done so. We accept that, but we expect to be reasonably treated so far as our status and remuneration are concerned.

THE PRESENT DISPUTE IN THE U.K.

Before we came into the Service certain committees known as the Spens Committees, were set up to determine the proper range of remuneration of the doctor with due regard to the desirability of maintaining in the future his proper social and economic status. The findings of these committees were accepted by the Government and the profession. We claimed, after the Service came into being, that these findings were not being translated into remuneration, having regard to the changed value of money and certain other factors. Our contention was upheld in 1952 by Mr. Justice Dankwerts in what came to be known as the Dankwerts Award.

As money depreciated the value of the award diminished. We asked for the difference to be made up. We used legal and moral arguments to support our contention. The Government refused to accept or to arbitrate on them. That was the dispute. The Government decided to set up a Royal Commission to compare the remuneration of doctors with that of other professions, to make recommendations for a range of remuneration, and possibly for a way to deal with such disputes in the future.

Subsequently, statements were made and promises given which, in fact, modified the terms of reference of the Royal Commission. A small interim adjustment in remuneration was made and we agreed to give evidence to the Royal Commission and await its findings.

The dispute, however, brought other anxieties to a head. In the hospital field there is a bottle neck. Many registrars with full consultant qualifications and training, although they have reached

the late thirties, cannot get consultant posts. Most of us think that there is need for an increase in the number of consultants. These registrars are necessary for the efficient working of the hospitals and in many cases they do a consultant's work. There are not enough vacancies and it is very difficult indeed for these men and women, at such a late age, often with family commitments, to carve out a career in any other branch of medicine.

Then again, it was confidently expected that the general practitioner would, in the new Service, come closer to the hospital by taking an increasing part in the work of the hospitals and by the increase in the number of general-practitioner beds. This has not proved to be the case. It is now almost impossible for a general practitioner (or a consultant) to change his type or place of practice once he is settled. And, finally, there is not sufficient incentive to the general practitioner.

The British Medical Association has decided that now that the Service has been in existence for nearly 10 years it is necessary to take a critical look at all its aspects, and we are appointing a committee with strong lay (i.e. consumer) interest to consider it.

CONCLUSION

This is a very big subject and I have tried to look at it from a wide angle so far as is consistent with the title. I have indicated some of the pitfalls, dangers and difficulties. The need for a Welfare State and the means used to provide it will depend upon the genius, desires and material welfare of the people of the State, but wherever the practice of medicine is involved the liberty of the doctor relative to his work, the preservation of his status in society—so necessary to his work—and his ultimate responsibility to the patient alone, remain paramount. It will behove the doctors of the State to be vigilant and united to this end.