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Services under the National Health Insurance Act

Anne Digby, *The Evolution of British General Practice 1850–1948* (Oxford, Oxford University Press, 1999), pp. 318–22.

Anne Digby's research has focused on the development of general practice in the nineteenth century, and especially on the economics of medical practice. In *The Evolution of British General Practice* she analyses the work and careers of ordinary general practitioners through a wide range of archival material and published medical journals. This extract examines the quality of state-funded primary care provided through the National Health Insurance Act of 1911.

[6] A euphemism for pregnancy. These advertisements were for drugs to induce abortions.

Amongst key issues posed by the NHI [National Health Insurance] was the question of whether panel patients were second-class citizens when compared to private patients. Informing discussion were implicit value judgements as to the appropriate standard to be sought in a public service catering for poorer patients. Class assumptions shaped the perceptions of bureaucrats as well as of doctors. English Insurance Committees were circulated on whether panel patients received as good a service as private patients, and the omissions and face-saving phraseology in their replies pointed to a divided system of medical care. An obvious indication of the two-tier nature of practice could be readily observed in the differentiated physical accommodation and reception of patients. Panel patients frequently queued at a back door to enter a cramped, barely furnished surgery, there to wait their turn for the doctor during fixed surgery hours. In contrast, their middle-class counterparts chose personally convenient times for appointments, were greeted by a maid at the front door, and waited in a comfortable room in the doctor's house for more extended medical interviews. Indeed, there was neither incentive for the panel doctor to improve accommodation, nor any effective coercion to do so, since although the rare insurance committee (such as Birmingham) inspected the surgery accommodation of insurance doctors several times, others (like London or Devonshire), did so only rarely or unsystematically.

The usual divide between panel and private patients was narrower in the Manchester and Salford Scheme. A local newspaper commented that 'it is to the doctor's interests to treat his panel patients with the same consideration he treats his private patients. Otherwise he would speedily find himself without any panel patients.' This local initiative was predicated on payment to doctors on the basis of patient attendance and not, as was the case elsewhere, on an annual capitation payment. Panel patients were therefore on the same footing as private ones. Running for only a dozen years, the scheme collapsed under the weight of the administrative work it had generated.

Insurance doctors had to give all proper and necessary medical services except those requiring special skill. This meant *inter alia*[7] that treatment of fractures or dislocation was expected but not an operation for piles or an operation on tubercular glands. More serious cases were referred for treatment in the outpatients departments of hospitals. Practitioners were supplied with 'Lloyd George' record cards for their NHI patients. Panel doctors recorded brief but intermittent entries for patients, usually in relation to more serious conditions, and/or those

[7] *inter alia*: among other things.

requiring certification in relation to employment. Diagnoses were almost entirely for physical ailments, and few clinical measurements were recorded as having been made in reaching them. Panel doctors seem to have shown little or no appreciation of the value of the NHI clinical record for their patients. The financial committee of one Scottish panel even minuted that 'the present medical record system is serving no useful purpose and in the interest of economy should be scrapped'. Patient–doctor confidentiality in relation to NHI certification was an issue raised by one NHI practitioner, who was outraged by the local insurance committee's insistence that the precise illness suffered by the panel patient be inserted on a certificate of incapacity for work. Interestingly, the point was made that 'health and character are so closely bound together that the declaration of a malady may blight the fair face of a whole family'. The doctor won his case, and the word 'illness' was deemed sufficient thereafter.

Doctors complained about the fluctuating composition of their panels, although this was usually articulated in a grouse about form filling, rather than in manifesting concern about its implications for the continuous care of patients—a defining characteristic of good general practice. Many panel patients moved on to a new doctor's list because of changes of address or of employment. Panel patients did have the right to choose their insurance practitioners, but only very small numbers (between 3 and 5 per cent) were estimated to have initiated a change in their doctor by giving notice at the end of a quarter. This finding might indicate either satisfaction with the standard of service or low patient expectation. That there was only a small trickle of panel patients' grievances about their doctors does not resolve this ambiguity. Complaints were usually about the practitioner charging for a procedure without prior warning, or charging for one which it was thought should have been in the category of insurance treatment rather than private practice. Also prominent were allegations that the doctor showed insufficient courtesy or did not respond promptly to a request for a visit. Discourtesy or incorrect charging were complaints which were far more likely to be upheld by insurance medical committees, and the patient vindicated, than were charges of medical negligence when doctors on NHI medical committees might feel impelled to salvage colleagues' professional reputations by finding facesaving rationales for their conduct. In some instances, however, a doctor was so clearly clinically negligent that he was severely censured, and a substantial fine was imposed. One Scottish doctor, for example, was fined £50. He had been sent for on a Saturday afternoon, failed to attend the panel patient until Sunday morning, when castor oil was prescribed, called subse-

quently on Monday morning, when the patient was sent to hospital, where death soon ensued from appendicitis. Friendly societies also criticized panel doctors for supplying inadequate certification in cases involving society members as insured patients; their allegations were well substantiated, and were usually upheld.

Standards of practice varied, not only (predictably) between individual doctors, but also in the standards laid down by insurance committees between different areas. Nottinghamshire, for example, debated the merits of a Local Formulary, such as that introduced into the City of Nottingham, by which a limited pharmaceutical range had been sanctioned for panel patients. It concluded that stock mixtures partook of club practice[8] would encourage hasty prescribing, lead to deterioration in the mixture during storage and, although producing economies, would not be in the interest of the insured person. Barrow in Furness, in contrast, was only too ready to sanction and introduce a local Formulary. Out of twenty-eight stock mixtures which the BMA and the Pharmaceutical Society of Great Britain listed as suitable for storing in bulk, the Barrow in Furness Insurance Committee selected only ten stock mixtures for use by its practitioners including cough mixtures, tonics, and digestive or laxative medicines.

If panel doctors prescribed expensive drugs they might be vulnerable to accusations of over-prescription, and liable to subsequent surcharging. The annual prescription cost of Fife panel doctors was continually singled out as having been well above the Scottish average. In 1925 nineteen local doctors there were even surcharged £100 each for their excessive prescription. The Fife insurance practitioners defended their expenditures on the grounds that they were due both to inexperienced panel doctors as well as to the prescription of new expensive drugs, such as extract of liver, which was 'of great therapeutic value'. Later, local doctors considered that this restrictive bureaucratic policy had been beneficially modified . . .

The calibre of NHI pharmaceutical practice has received little academic attention, but it is obvious that the predominance of small chemists, making up a few NHI prescriptions for a handful of doctors, was unlikely to encourage accurate dispensing. When the Nottinghamshire Insurance Committee inquired into panel prescriptions, the analyst they employed found that as many as one in three were substandard. Generally, new drugs were not sanctioned for NHI use, because it was stated that 'as a specific it is still in question', but to the

[8] *club practice*: practice through private insurance schemes or 'sick clubs'. Club practice had a reputation for providing low standards of care, in order to keep down costs.

historian the suspicion lingers that its cost was the material factor. Appliances which were sanctioned by the NHI authorities in each locality were listed. These might include cheaper alternatives to those which doctors were accustomed to use, and Burnley doctors protested, for example, about the cheaper grey bandages they were expected to substitute for white ones for their panel patients.

For the patient the 1911 act brought real, if heavily qualified, blessings. A panel doctor concluded that 'the Insurance Act was a boon both to the insured patient and to their medical attendant.' The doctor was no longer involved in 'balancing the value of his services against the length of his patient's purses', while the patients were not faced with bills and debts. But although access to a doctor undoubtedly improved after 1911, the quality of care given was generally mediocre. Club doctors before the NHI had reduced visits in favour of a swift throughput through the surgery, and the panel doctor continued with this. The panel system therefore institutionalized a pre-existing tension between the club doctor and his patient in that it emphasized the quantity of care delivered rather than intervening to improve its quality. Routinization linked to a low standard of patient care: with overprescription; a reluctance to treat difficult cases rather than to refer them elsewhere; and under-investment in modern equipment and premises were thereby encouraged. This trend was linked to the capitation system[9] of British insurance practice. In Germany where doctors were paid through items of service, insurance practitioners were encouraged to offer specialist as well as generalist services to their patients.

It was almost inevitable that the pressure of treating large numbers of patients should have had an adverse impact on the range and quality of patient–doctor encounters. A reluctance by panel doctors to engage in clinical work for which no remuneration was likely, meant a readiness to refer patients to hospital outpatient clinics. Even Dame Janet Campbell (formerly in the Ministry of Health), admitted that 'Panel practice does not justify the keen doctor . . . Work is hard, hours are long'. At that time the doctor gave on average three-and-a-quarter minutes to each insurance patient in the surgery, and four minutes when on a visit to the patient's home. But perhaps we should not be too critical on this score: it was not very different from the five minutes that the NHS doctor later spent.

[9] *capitation*: payment according to the number of patients, regardless of how much treatment was provided.