Document generated on 12/13/2024 9:29 a.m.

Assurances

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L'assurance-santé en Angleterre

Volume 19, Number 3, 1951

URI: https://id.erudit.org/iderudit/1103216ar
DOI: https://doi.org/10.7202/1103216ar

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Publisher(s)

HEC Montréal

ISSN

0004-6027 (print)
2817-3465 (digital)

Explore this journal

Cite this document

(1951). L'assurance-santé en Angleterre. *Assurances*, *19*(3), 125–128.
https://doi.org/10.7202/1103216ar

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L'assurance-santé en Angleterre

A plusieurs reprises, nous avons fait paraître dans notre revue des études sur l'assurance-santé en Angleterre. C'est avec plaisir que nous reproduisons ici les conclusions du professeur Seymour E. Harris, de Harvard University, extraites d'un travail que celui-ci a présenté au congrès de l'American Association of University Teachers of Insurance, en décembre 1950. Nous les tirons du *Journal of the American Association of University Teachers of Insurance* de Mars 1951:

Summary and Conclusions.

The new British Health Insurance Program has now been in operation more than two years. Physicians both in Great Britain and in this country seem divided on the issue of the successful outcome. At least this much is clear :

1. The effect of N.H.I. is to channel additional money and resources into the health services.

2. Through appropriate tax and pricing policies, the government modifies the spending pattern in favor of medicine (and other social services) and against outlays for tobacco, alcohol, clothing, durable consumers' goods and other commodities.

3. Additional medical service is not merely at the expense of more production or more desired goods and services. First, because more intensive use is made of existing facilities and personnel. Second, because diversions are made from luxury medicine. Third, because in part the consumption of less necessary goods is foregone. Fourth, because better health means less illness and higher output.

4. The pattern of spending the medical sterling has greatly changed under N.H.I. The explanation of this fact lies partly in the intensive use of services previously denied the masses — e.g., dental service (only 7 per cent availed themselves of this service under the previous insurance program and almost one-half in a recent year). But in part the changes stem from the abuses that develop under the system — e.g., excessive prescriptions, and in part, the method of payment — designed to increase outlays on hospital and specialist services.

5. It is not clear that the most effective system of payments has as yet been evolved. The objectives are the maintenance of required incentives, economies of total outlays, relative payments consistent with the required distribution of man-power, and the absence of obstacles to effective use by the insured. On these criteria, the practitioners probably require somewhat larger rewards; the dentists less; and the practitioners with small lists, higher per capita rewards for the first 1,000 (and related higher rewards in outlying areas). Possibly, a small charge for some services may be necessary to discourage waste. But this should be a measure of least resort.

6. There is no convincing evidence that the British cannot afford the 400 million sterling being spent on health services. In relation to income, total and per capita, the outlays are less than in the United States. As a contribution towards inflationary pressure, the importance of health services has been greatly overestimated — and especially by physicians. The government for several years has been operating on a budgetary surplus; and the wherewithal to finance the special services has come largely from the beneficiaries. Higher taxes on consumption goods and on income paid primarily by the masses finance the increased services received.

7. British health insurance necessarily stresses quantity, not quality. The objective was to make medicine available to all, not to a limited number. Perhaps the most tenable criticism to be made against the N.H.I. was the introduction of comprehensive services before some of the necessary facilities were available. It might have been preferable to postpone some services or maintain small charges until dentists, nurses, hospitals, prosthetics, etc., were available in larger quantities. The deterioration in quality need, however, be only temporary.

8. Perhaps the most frequent complaint made against N.H.I. is that the general practitioner has lost position and financial status. This deterioration is partly the result of large demands on other medical services; but it is also the result of the pressure resulting from the availability of practitioner's service without financial check. The physician earns more but not nearly in proportion to the additional work; and the specialist and the dentist have gained at his expense. Note, however, that in comparison with the factory worker, the British physician earns four times as much; in the United States, the proportion between earnings of physicians and factory workers is about the same. In the rate of pay for service, in the degree of association with hospitals, and continuance of same specialist work, the practitioner can rightly expect some improvement.

9. As the program continues, we may expect much improvement: Education of the people concerning rights and duties; satisfaction of backlog demands; improved distribution of physicians in response to differential rewards (e.g., higher pay), in areas of shortages, and control of entry; more careful scrutiny of prescriptions; improved structure of pay for dentists, practitioners, and specialists; growth of health

centers, with their improved services and economies of operation; increase of medical personnel — all of these will help.

10. Finally, the British experience is one that all interested in compulsory health insurance will watch. The British have moved quicker than this country, in part because the philosophy of the Welfare State is more generally acceptable in the United Kingdom and in part because with much lower incomes, the need for an improved consumption pattern is much greater. Perhaps the most significant British mistake from which we might profit has been the introduction of comprehensive N.H.I. before the required facilities were available.